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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

9 February 2002

Scotland gives pharmacy the Right Medicine

Government confirms plans for pharmacy

Enigma PMR moves into next phase

How pharmacy is going to evolve by 2005

SPECIALISTS

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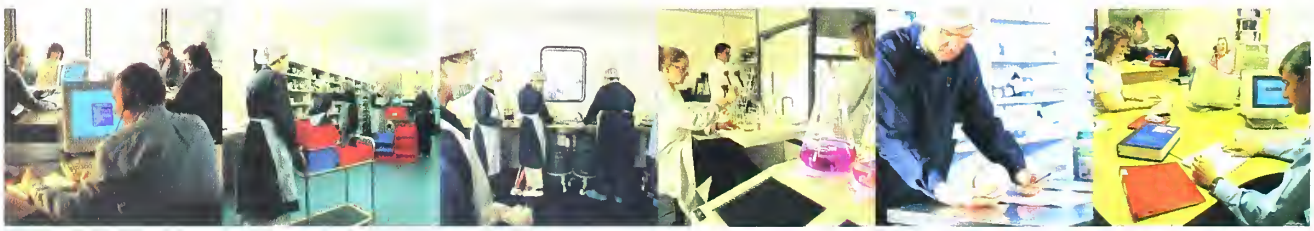

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Scottish pharmacy strategy launched

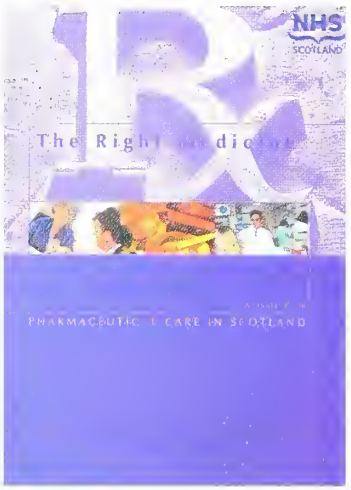
Pharmacists in Scotland can look forward to a greater profile and more responsibilities following Monday's publication of the Scottish Executive's pharmacy strategy.

Around £750,000 is being provided for more improvements to pharmacy premises. There are prospects of repeat dispensing and limited prescribing on the NHS by pharmacists. A greater role in public health will include a series of health promotion campaigns in pharmacies, such as a major campaign on the safe storage, use and disposal of medicines.

Skill mix issues are to be considered to allow pharmacists to undertake more outreach work, and more collaborative working with other health and social care professionals is anticipated. Certain patients will be able to have a medicine review by a pharmacist to encourage concordance.

A new system of remunerating contractors will be introduced by the end of 2005, and is likely to have local pharmaceutical service (LPS) schemes as part of the package. IT links will also be rolled out, following the pilots in Ayrshire and Arran for electronic prescribing which go live later this month.

The strategy has been drawn up from much of what has already been successfully piloted in Scotland and elsewhere. A four-year timetable included in the document will make it easier to hold the Scottish Executive Health Department to account in terms of delivering the strategy. Scotland will also get its own adverse drug reactions reporting centre.



Announcing the strategy, health minister Malcolm Chisholm said *The Right Medicine: A Strategy For Pharmaceutical Care In Scotland* is a "bold and innovative plan". He highlighted five key areas in which the strategy will make a difference:

- improved access to pharmaceutical services
- better and safer use of medicine
- improving premises
- harnessing IT
- developing the pharmacy workforce.

Individual components singled out by the minister included:

- area pharmaceutical committees will be asked to review local arrangements for out of hours services to improve access
- the rolling out of a scheme to allow certain patients to obtain their OTCs from the pharmacy on the NHS
- repeat dispensing schemes to allow pharmacists to manage patients' medication for up to 18 months between GPs re-examining the patients.

The minister also announced that £548,000 would be provided to enable 10 pharmacies to be modernised to become model twenty first century premises. And £4 million has been earmarked within the 2003-04 budgets of NHS Boards as there is a "need to deliver a number of key recommendations early if the strategy is to be credible".

Chief pharmacist Bill Scott has emphasised the training and education aspects of the strategy, and the need to ensure there is an appropriate workforce. He believes the prospect of "professional doctorates" will be one way of encouraging continuing professional development among pharmacists, as well as a means of providing a research base of clinical pharmacy practice. The plan also makes a commitment to making CPD compulsory for practising pharmacists by 2005.

The strategy has been welcomed by the pharmacy organisations in Scotland, who are pleased that the strategy supports the retention of the pharmacy network.

Scottish General Pharmaceutical Council chairman Frank Owens said: "I am delighted the Scottish Executive recognises the potential for community pharmacists to assist in improving access to services and welcome the commitment to making better use of pharmacists' expertise in planning and delivering services."

He was particularly pleased that the strategy would encourage the development of community pharmacies as walk-in "healthy living" centres.

Alison Strath, chairman of the Royal Pharmaceutical Society in Scotland, warmly welcomed the strategy. She believes the repeat dispensing proposal will be a key driver for change as it will provide a framework on which quality measures can be built. It will also drive the pharmacist prescribing agenda forward.

She advised pharmacists not to be worried by the scale of potential change, but to look at the time frame for delivering the strategy, much of which has already been tested in pilot schemes.

Ian Johnstone, Scottish Pharmaceutical Federation chairman, said the document was "broadly in line with the direction we wish to see pharmacy services take". However, he is awaiting discussions with the Executive and wants to examine costings for the proposals.

Copies of the document will be sent to all practising pharmacists and pre-registration students in Scotland, as well as GP practices.

Ms Strath said the next step would be for the pharmaceutical groups to discuss the strategy after considering its contents.

Mr Scott will be establishing implementation committees to meet the deadlines set out in the strategy.

For more information:
http://www.scotland.gov.uk/pages/news/2002/02/SE5292.aspx

Pharmacy advisor chosen for NHS 24

NHS 24, the nurse-led telephone triage service due to be launched in Scotland this spring, has appointed Debbie Jamieson as pharmacy advisor.

Ms Jamieson will be responsible for setting up the pharmacy [illegible] which will allow the service to direct callers to their local community pharmacist.

Her other roles include advising NHS 24 on pharmaceutical issues, the development and provision of induction training and continuing professional development on pharmacy issues for NHS 24 nurse advisors. She will also develop procedures to audit the handling of callers with pharmacy-related enquiries.

"This is a great opportunity for pharmacy as it recognises the valuable role of community pharmacists," said Ms Jamieson.

"The success of the pharmacy interface may even provide evidence for future service development in community pharmacy, such as pharmacist prescribing for minor ailments."

NHS 24 will launch in Grampian and be rolled out over the rest Scotland over the next three years. NHS 24 will be holding briefing evenings with pharmacists in Grampian this month.

For more information:
www.nhs24.com

Three wise pharmacists: showing their delight at the launch of the Scottish pharmacy strategy on Monday are (from left) Scottish Pharmaceutical General Council chairman Frank Owens, Royal Pharmaceutical Society in Scotland chairman Alison Strath and the Scottish chief pharmacist Bill Scott

EHC to have a judicial review

A High Court hearing next week will decide whether pharmacists will be able to supply emergency hormonal contraception in future.

The Society for the Protection of Unborn Children's judicial review of over the counter sales of EHC will begin on February 12.

A spokesman for SPUC said it had every confidence in pharmacists' skills and was not denigrating their ability to supply medicines. However, it argues the pharmacy supply of EHC contravenes the 1861 Offences Against the Person Act which prohibits the supply of any "poison or other noxious thing" with intent to cause miscarriage.

SPUC says that pregnancy begins with the fertilisation of the egg, not when it is implanted in the endometrium.

A judgement in SPUC's favour could also affect the prescribing and dispensing of all other forms of contraception that prevent implantation of a fertilised egg.

Beverley Parkin, director of public affairs at the Royal Pharmaceutical Society, said it was very concerned about the High Court hearing.

"We are very proud of the service and know pharmacists want to keep providing it," she said.

Government's Action Plan covers pharmacy reforms

A timetable for pharmacy reforms – part of a wide-ranging shake-up of legislation for businesses and consumers – has been published this week.

The *Regulatory Reform Action Plan* is the Government's strategy to make legislation for businesses and consumers more transparent, consistent and proportionate. It covers over 260 proposals with target completion dates.

Plans that affect pharmacy include:

- The introduction of supplementary prescribing for pharmacists early in 2003, with a consultation this spring. Pharmacists will be able to prescribe for named patients under a clinical management plan, following diagnosis by a doctor.
- A change to the regulations under the Misuse of Drugs Act 1971 to allow pharmacies to keep computerised records of controlled drugs issued; legislation for this is planned for early next year.
- By 2004, patients with stable chronic conditions will be able to obtain prescriptions which can be dispensed in instalments, rather than going back to their GP each time they need a new prescription.
- The electronic transmission of prescriptions is to be routine in the community by 2004. The Government expects the current ETP pilots to be complete by this autumn, with evaluation due at the end of the year.
- Reform of self-regulation in the healthcare professions to make them more open, responsive and accountable. This is to be completed as soon as parliamentary time allows.
- The introduction of electronic patient records in hospitals – the records will be available to all those authorised by the patient. A timetable for implementing this will be issued this spring.
- By April 2002, legislation on medicines classification will be in place to encourage the pharmaceutical industry to make suitable medicines more widely available.

Health Minister Lord Hunt welcomed the report and said: "The Government is committed to maintaining a careful balance between delivering quality patient care in the NHS and in social care, whilst avoiding unnecessary burdens on staff, businesses, charities and voluntary organisations. We are determined to improve the quality of regulation and ensure that it is necessary, fair, affordable, simple to understand and will command public confidence."

For more information:
www.cabinet-office.gov.uk

Travel fund announced

A travel fellowship to mark the Queen's Golden Jubilee is being offered by the Commonwealth Pharmaceutical Association and Royal Pharmaceutical Society.

The fellowship, worth £2,000, will be awarded to a young pharmacist to enable them to visit another Commonwealth country.

Applicants must be a registered pharmacist in a Commonwealth country and need to submit their application by May 1. Further details are available from the CPA secretariat at 1 Lambeth High Street, London SE1 7JN.

New training module

The second of Nelsons' four modules, *How to Counter Prescribe a Selection of OTC Homoeopathic Remedies*, is now available. Over 1,600 pharmacists have registered for Nelsons' homoeopathy training modules, which were launched in November last year.

For more information:
E-mail: nelsons@precisiondbm.com
Tel: 0800 783 6434.

Continue to excel with Crookes

Look out for the second module of the *C&D*/Crookes Pharmacy Business Excellence course, which is enclosed in this issue.

It contains a step by step guide on how to market your pharmacy.

The third and final module, which covers selling skills, will be published in the April 6 issue of *C&D*. This module will also explain how to enter the Crookes Business Person of the Year competition with the chance to win £2,500 worth of Crookes' Healthcare brands.

To use the course's free telephone marking system you must have registered using the insert enclosed in the first module. Alternatively, you can register by calling Mary Prebble on 01732 377269.

MS treatments to be made available on the NHS

The community pharmacy supply of drugs for multiple sclerosis should not be affected by the changes proposed by the Department of Health this week. However, as *C&D* went to press it was uncertain whether the reimbursement process may alter.

Following guidance from the National Institute for Clinical Excellence that beta-interferon and glatiramer could not be recommended for supply on the NHS on the basis of their clinical value or cost-effectiveness, the DoH immediately announced a new scheme to supply patients with the treatments. These arrangements will apply throughout the UK.

From May, patients meeting eligibility criteria will be supplied the appropriate drug as part of a "payment by results" scheme negotiated by the DoH and the pharmaceutical companies. The eligibility criteria, devised by the Association of British Neurologists, means that an estimated 10,000 patients with relapsing/remitting or secondary progressive MS will receive treatment.

Patients will be monitored over 10 years and the payment to pharmaceutical companies will be reduced on a sliding scale based on agreed patient outcomes. The cost of treatment will be an estimated £50 million annually and health authorities and primary care trusts will be expected to fund the treatments immediately out of their general allocations.

The MS Society has welcomed the arrangements. Ken Walker said: "The DoH is to be congratulated on acting imaginatively to end the nightmare which started with the postcode lottery and continued through two and a half years of NICE incompetence and intransigence, during which many people have become too disabled to qualify for the drugs."

The DoH suggests that pharmacists may need to submit payment claims to the local HA or PCT. However, on Wednesday the PPA was unaware of any changes.

For more information:

www.doh.gov.uk

POLICY

Training for POM to P switches

A working group involved in the new POM to P reclassification process has urged manufacturers to show that they have considered health professional training when planning to switch a product.

The information and training group (*C&D, February 2, p36*) has published the proposal in *Information and training needs for potential switch candidates.*

The group, led by the Proprietary Association of Great Britain, also proposes:

- adequate training procedures could be enshrined in a *Reclassification Code of Practice.* These could, at least, be developed in preparation for the planned reclassification
- where manufacturers are the sole providers of training materials, representatives of the health professions who need the materials should be involved in developing or reviewing them
- training for health professionals should include information about the product, how it is used in the context of current treatment options, common questions likely to be raised by users, the information to be given on side-effects, alternative treatment options and self-help options.

Other issues raised by the group included:

- the need for better record keeping and a cultural change in the relationship between doctor, patient and other healthcare professionals towards sharing management
- a greater awareness among doctors of products available both as OTCs and on prescription.

Lloydspharmacy has welcomed the proposed list of POM to P switches (*C&D, February 2, p4*). Andy Murdock, the company's superintendent pharmacist, said: "Any proposal that moves pharmacy forward and recognises the skills and expertise of pharmacists is welcome." However, he was concerned about the implications of an increased workload in pharmacies if there was more than one product switched at a time.

Lloydspharmacy is planning to respond to the consultation document by the end of March.

For more information:

www.pagb.co.uk

'Pharmacists get raw deal'

Taunton MP Adrian Flook has said that pharmacists are getting a raw deal, after being told how the Government's actions are demoralising pharmacists.

Mr Flook's comments came during a recent visit to Chapmans Chemist near Taunton. He was invited by Mike Chapman, the owner and Somerset Local Pharmaceutical Committee member, and Peter Whitaker, the pharmacy manager.

They talked mainly about the pressures contractors face after the cut in dispensing fees.

The MP was told that contractors feel "aggrieved, demoralised and let down", said Mr Chapman.

Responding in the local press, the MP said: "I want to hear first hand the serious problems this is creating for pharmacies in my constituency. When the Government says it is putting more money into the NHS, it appears it is taking some of it direct from the pockets of the small businesses that help the NHS provide its service."

MEDICINES

OTC cough remedies

NHS Direct should restrict advice on the use of over the counter cough remedies until there is more evidence of their effectiveness, says an article in this week's *British Medical Journal.*

The review of 15 randomised controlled trials said that there was conflicting evidence on their effectiveness compared to placebo.

For more information:

www.bmj.com

BMJ 2002; 324: 329-331

Questiontime

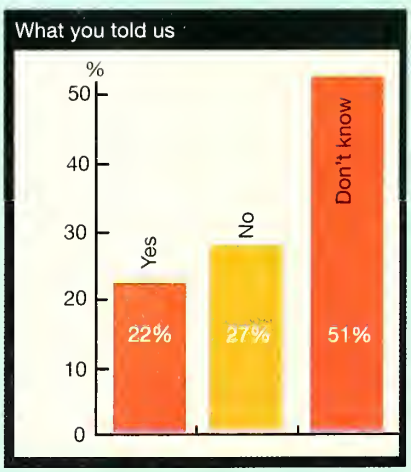
Do you see pharmacists as key advisors for information about the MMR vaccine?

- Yes
- No
- Don't know

You can record your vote on our website: *www.dotpharmacy.com*. Question Time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated.

You have until noon on February 12 to cast your vote. We will publish the result in *C&D*, February 16.

Last week we asked you: Should Schering Health Care withdraw its "morning after pill", Levonelle, to the public?



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Abbreviated Prescribing Information

Product Name: Ciprofloxacin 100mg, 250mg, 500mg 750mg Tablets. **Active Ingredients:** Film-coated tablets 100mg contains 116.6mg of Ciprofloxacin hydrochloride, 250mg contains 291.5mg of Ciprofloxacin hydrochloride, 500mg contains 583mg of Ciprofloxacin hydrochloride, 750mg contains 874.5mg of Ciprofloxacin hydrochloride **Indications & Dosage**: Treatment of infections caused by ciprofloxacin-sensitive pathogens. Consider infection severity and type, organism sensitivity, and patient age, weight and renal function to determine dose and duration of treatment. *Adults*: oral dose range is 100-750mg twice daily, swallowed with liquid. Ingestion on an empty stomach accelerates absorption. Dairy products such as milk or yoghurt may reduce absorption. Respiratory tract infections/ pneumonia due to gram negative pathogens (ciprofloxacin is not the 1st drug of choice for outpatient pneumococcal pneumonia) 250-500mg twice daily for 7-14 days; acute uncomplicated cystitis in women 100-250mg twice daily for 3 days; complicated UTIs/pyelonephritis 250-500mg twice daily for 7-14 days; prostatitis 500mg twice daily for up to 28 days; gonorrhoea (acute uncomplicated) 250-500mg single dose; severe gastro-enteritis 500mg twice daily for 3-7 days; skin & soft tissue infections 500mg twice daily for 5-10 days; bone and joint infections 500mg twice daily for 4-6 weeks or longer; severe systemic infections 500-750mg twice daily. *Children (5-17 years of age)*: Acute pulmonary exacerbation of cystic fibrosis caused by Pseudomonas aeruginosa orally 20mg/kg twice daily (max 1500mg daily) for 10-14 days. Other indications not recommended. *Elderly/Impaired Renal Function*: Creatinine clearance may necessitate dose adjustment (see SmPC for full details). Impaired Hepatic Function: Dose adjustment not necessary. **Contra-indications**: Hypersensitivity to the active ingredient, excipients or any other quinolone agent, pregnancy; breastfeeding, history of tendon disorders related to fluoroquinolone administration; children under 5, children 5-17 years of age except for licensed indication shown above **Precautions & Warnings**: Epilepsy/other CNS lesions-only use after assessing benefit vs. risk, crystalluria has been reported-patients should be well hydrated & avoid excessive alkalinity of urine, discontinue use if severe & persistent diarrhoea develops & doctor to be consulted; caution use in patients with family history of or actual G6PD activity defects, avoid prolonged exposure to sunlight, tendon damage risk-discontinue after first signs of pain or inflammation & rest affected limb until resolved, false negative culture of M. tuberculosis during ciprofloxacin treatment may occur, caution use in myasthenia gravis; perform microbiological studies for resistance if treatment fails vs. P. aeruginosa or Staphylococcus. **Interactions**: Antacids, iron, zinc, sucralfate, calcium, didanosine, oral nutritional solutions, dairy products, xanthine derivatives, NSAIDs, cyclosporin, warfarin, glibenclamide, probenecid, metoclopramide, mexiletine, phenytoin, premedicants, ropinrole. **Side-Effects**: Most commonly nausea, diarrhoea, vomiting, digestive disorders, abdominal pain, flatulence, loss of appetite, dizziness, headache, tiredness, agitation, tremor, confusion, skin reactions. See full prescribing information for less common side-effects. **Licence Holder**: Alpharma Limited (Trading style: Alpharma, Cox Pharmaceuticals), Whiddon Valley, Barnstaple, Devon, EX32 8NS. **Product Licence Number**: 100mg PL 0142/0475, 250mg PL 0142/0476, 500mg PL 0142/0477, 750mg PL 0142/0478. **Legal Category:** POM, **Date of Preparation**: January 2002. For full prescribing information, log on to our website www.accessiblemedicine.co.uk/medloc/UK/index.htm

BGMA warns on patient packs

The unresolved situation over patient packs could put pressure on manufacturers to revert to bulk packs for certain products, John Beighton, the new chairman of the British Generic Manufacturers' Association, has warned.

Bulk packs have not yet been phased out, as envisaged by the patient pack initiative prior to the 1997 election, and currently co-exist with patient packs.

Mr Beighton stressed the significant investment generic manufacturers had made with patient packs and said that this "commitment has not been matched by others".

He said he could understand why economic pressures were forcing manufacturers to go backwards and produce bulk packs, and he called on the Government to take a lead and remove the need for bulks.

While his own company, APS Berk, has not reverted to producing bulks, Ivax said it was considering offering some products both as bulk and patient packs. Alpharma, which provides thyroxine tablets in patient pack sizes of 28 tablets, will launch an additional bulk pack of 1,000 tablets following a direct request from the Medicines Control Agency. The bulk packs will be available to pharmacists and wholesalers from March this year.

John Beighton: patient pack commitment has not been matched by every manufacturer

Outlining his priorities for his first year as chairman, Mr Beighton said the BGMA would work vigorously to ensure that generic launches would not be delayed by branded manufacturers using or abusing data exclusivity provisions, under current or proposed legislation.

He also promised to ensure that the market for a generic could not be killed off by companies, whose brands are due to come off patent, through withdrawing their brand and launching a similar product with no added benefit to patients.

Speaking on the proposed changes to the supply and reimbursement of generics, Mr Beighton insisted that any new system needed to guarantee the continuity of supply, and fair commercial returns for manufacturers, wholesalers, and retail pharmacy.

MULTIPLES

Boots to train new audiologists

Boots is offering free audiology training to address a shortage of hearing aid audiologists – providing they agree to work for the company for three years.

The Boots School of Audiology offers a 23-week programme that combines a residential phase and supervised work experience. It leads to a professional qualification from the Hearing Aid Council.

Boots recently entered the hearing care market with the launch of Songbird, the world's first disposable hearing aid.

ONLINE

Pharmology upgrades

UniChem's pharmacy portal, *pharmology.com*, will be inaccessible until Tuesday February 12, while new features relating to e-commerce and pharmacy-related information are loaded onto the site.

How to deal with awkward customers

The Pharmaceutical Society of Northern Ireland has been investigating what guidelines exist for dealing with unwanted or unpleasant behaviour by customers.

The action follows reports of a man approaching a female pharmacist to ask about contraception for his wife. The man is then said to have tried to talk to the pharmacist about sexually explicit matters.

At its December meeting, the Society's Council heard that other organisations had been approached to ask if their Codes of Practice included guidance on how to deal with incidents of a sexual nature. However, no guidelines had been received.

Other matters discussed at the meeting included:

Sheila Hillan and Dr Kate McClelland, who suggested that the doctors were unhappy with many aspects of developments in primary care. There were also concerns regarding continuing professional development and the perception that the doctors were relinquishing their self-regulatory powers.

Mrs Maltby had met with the RPSGB to discuss the NHS and Healthcare Professions Reform Bill.

Professor McElnay referred to the proposed changes in legislation and said that the Society should be looking at appointing lay representation onto Council to increase the variety of skills and experience. It was acknowledged that this would need a change in primary legislation and it was agreed that this should be examined by the Law and Ethics Committee.

On the matter of CPD it was agreed that Mrs Maltby would talk to David Bingham, director of human resources at the Department of Health. Areas needing clarification included pharmacists returning to the Register after long periods of absence and those registering from abroad.

Pharmacists were to be sent a questionnaire in January asking them to confirm whether or not their pharmacy staff had completed an authenticated counter assistants training package training course.

The Society agreed to pay for the Certificate in Community Pharmacy Management for pre-registration students, but was seeking additional sponsorship to cover costs.

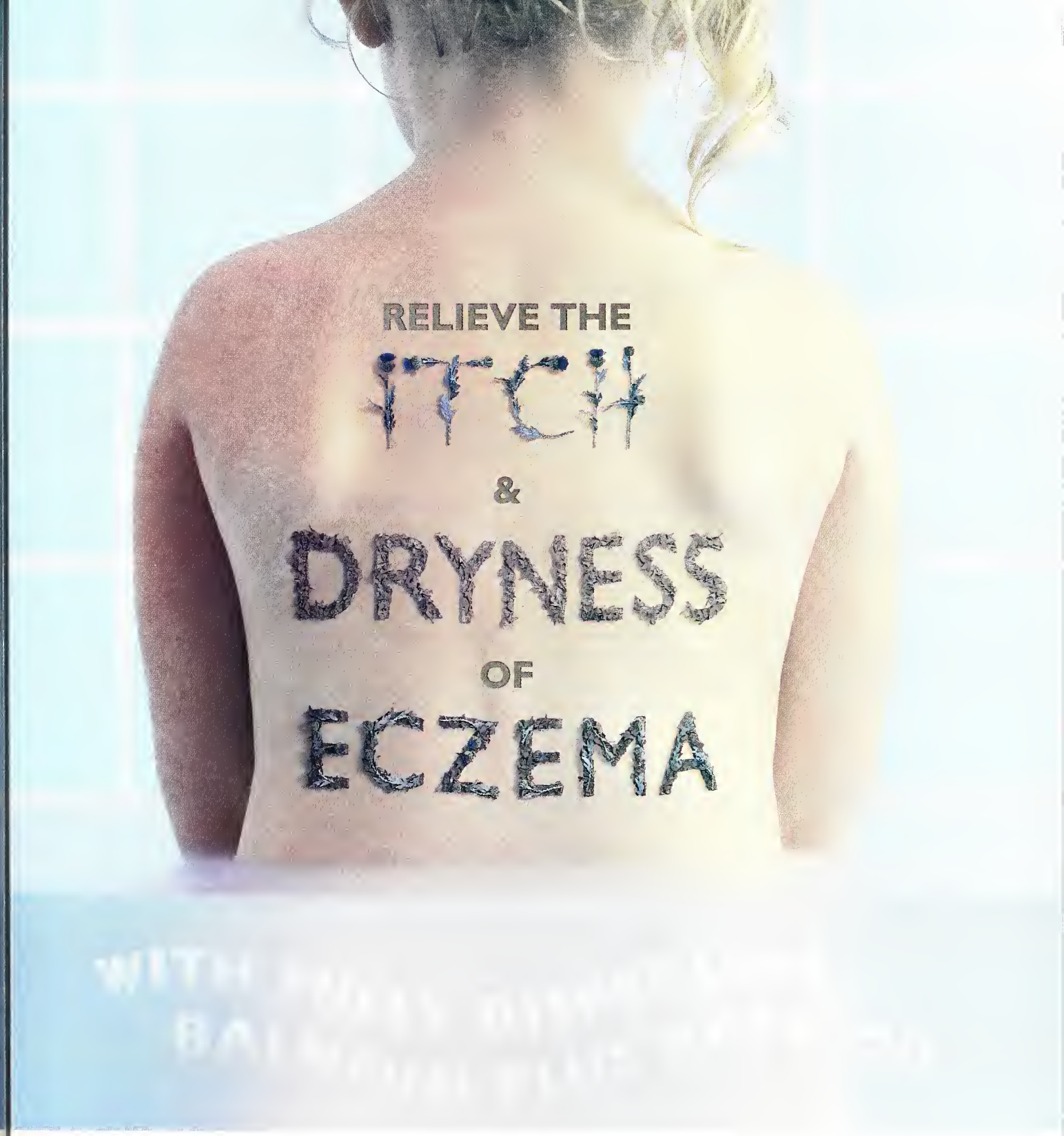
Funding of the first aid course was discussed. Possible options include a one-day course for the students with St John's Ambulance, or buying some first aid manuals from the National Pharmaceutical Association. In the future it was hoped to organise a distance learning module.

Council agreed that Dr Terry Maguire should take responsibility for running the pre-registration tutor course as in previous years.

It was agreed that the Society would write to the DoH before the end of March and ask that the Society increase the students' fees to £300 from June 1.

The Council noted that Dr Glenda Fleming has been appointed as the liaison development manager for pharmacy in Northern Ireland within the R&D office.

● On Wednesday, Mrs Maltby announced that the next Statutory Inquiry has been scheduled for February 21.



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- Soya oil contained in Balneum Plus replaces oils lost by the skin.[3]
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Prescribing Information **Balneum(fr) Plus** An oily liquid for external use containing soya oil 82.95% w/w and mixed lauromacrogols 15% w/w **Uses:** for the treatment of dry skin conditions including those associated with dermatitis and eczema where pruritus is also experienced **Dosage and Administration:** Normally 20ml (1 measure) for a full bath or 2.5ml for a partial bath. If required, this can be increased to x3 times this amount. Add to bath water and mix well. Frequency and duration of application depend upon the type and severity of the condition. Adults should use the bath oil frequently, at least 3 times per week. For babies and infants a 5ml measure for a bath and daily application is recommended. Balneum Plus can also be used in the shower by applying evenly without dilution and rinsing away excess by showering. **Contraindications, warnings etc:** Contraindicated in patients hypersensitive to any of the ingredients. Care should be taken to guard against slipping in the bath or shower. Avoid contact of undiluted product with eyes, if this occurs, rinse immediately with water. **Package quantities:** Bottles of 500ml. **MRRP cost:** £13.22 **Legal category:** GSL. **Product licence number:** 00327/0110. **Product licence holder:** Crookes Healthcare, Nottingham, NG2 3AA. **Date of Preparation:** November 2000. **References:**

1. Cork MJ. Complete Emollient Therapy In: The National Association of Fundholding Practices Yearbook, 1998. The Independent Community Pharmacist 1999; April:52. Kopeka B and Borelli S. *Praxis* 1964, 53(48):1630-32

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We have excluded from the table any policies where special conditions apply. Past performance is not a guarantee of future returns, as these depend on bonuses yet to be declared. If you cash-in early you may get back less than you paid in. *Source of figures: Moneyfacts, October 2001. The savings table above shows the actual maturity values of a Liverpool Victoria full cost with profits endowment plan taken out by a male aged 29 and 11 months at outset contributing £500 a year. The Regular Savings Plan was not available 10 years ago and varies from the example above in that your money buys units in the With Profits Fund. This past performance example is included as a guide only of the results achieved for past policyholders. You should be aware that if inflation and investment returns continue at the lower levels we've seen over the last few years, then future payouts will be lower than in the past. Future reductions could be substantial. We do, however, aim to produce a competitive rate of return in the current low inflation environment.

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Source: Money Marketing with profits unit linked survey June 1999, 2000 & 2001

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Enigma PMR enters next phase

Enigma Health has launched its next generation pharmacy business system, NEXphASE, an upgraded, fully web-enabled and Windows-based version of the company's Mediphase system.

The patient medication records (PMR), which remain at the heart of the system, have been connected to the internet, preparing it for the electronic transfer of prescriptions (ETP).

The system already offers patients a repeat prescription service. To use it the patient signs up with a pharmacy, which will then issue an Enigma customer number, enabling the patient to log on to the Enigma website.

Once logged on, the patient enters a "virtual pharmacy" where repeat medication can be ordered and its progress checked. Messages can also be sent from the pharmacy to the GP or vice versa.

In addition, the virtual pharmacy provides access to information regarding drugs, conditions and lifestyle. The patient logs out via the designated pharmacy's website, which Enigma will host without charge.

With ETP pilots only at an early stage, patients cannot yet be connected to the GP surgery directly, but Maurice Leaman, Engima's director and one of the founders of the Mediphase system, said it was important to prepare the ground for future developments.

Launching NEXphASE: left, Ahmed Saley, Enigma Health's head of professional services, Michael Major, chief executive, and Maurice Leaman, director

"The challenge has changed from ensuring correct invoicing of the Government to making sure that pharmacy is not sidelined," Mr Leaman said.

He said the system could deal with electronic prescriptions when the need arose. Enigma may yet join one of the consortia piloting ETP – Mr Leaman said a decision was imminent.

Meanwhile, Michael Major, Enigma's chief executive, said Enigma cannot identify patients through the customer number as their prescription and personal details are kept separate. The latter are only accessible at the pharmacy.

Other core functions of NEXphASE include labelling, ordering and endorsing using an enhanced endorsing engine.

The new system will carry the same charge as the current Mediphase system, but some older computers may need to be upgraded or exchanged.

Minimum requirements to run NEXphASE are an Intel Pentium III processor and 128mb RAM.

Enigma expects that 20 per cent of systems currently operated by Mediphase users will have to be replaced and another 40 per cent may need a minor upgrade.

Roll-out of the system has already begun and Enigma is planning to run several roadshows later this year.

All 4,000 Mediphase customers have been invited to convert to NEXphASE, but Enigma hopes that with the exclusivity to UniChem customers now abolished, it can add 1,000 new customers by 2004.

It also plans to launch various medicines management programmes for the system.

No details were available regarding the proposed integration between NEXphASE and pharmology, Alliance UniChem's pharmacy portal.

UniChem's management services director, John Davidson, said that "pharmology and NEXphASE are two separate and distinct systems, and are being launched as such. As with any web-orientated product there are some inevitable common elements of functionality. Once established, there may be an opportunity to enhance any overlaps between the two systems, thereby developing a full feature pharmacy operating system."

Novartis says goodnight to Ovaltine as part of sell off

Novartis is to sell its health and functional food (HFF) business, which includes well known brands such as Ovaltine and Isostar.

Last year the HFF business saw sales of Sfr 850 million (£354m).

The move is intended to increase Novartis's focus on healthcare, particularly pharmaceuticals.

"Our health and functional food brands are strong and well established, and we believe their growth can be accelerated in companies where there is a good strategic fit," said Dr Daniel Vasella, Novartis's chairman and chief executive.

The remaining businesses within Novartis's consumer health sector are OTC, Infant & Baby, CIBA Vision, Animal Health and Medical Nutrition.

RETAILING

Boots denies Sainsbury's pilot is ready for roll out

Boots has played down a press report that it is about to roll out its pilot with Sainsbury's supermarkets.

An article in the *Mail on Sunday* claimed that Boots intended to close 100 high street stores and relocate the NHS contracts into Sainsbury's stores. However, Boots insisted that the trial was merely exploratory. It said: "As part of our forward planning, we are currently carrying out a review to establish where relocation of a contract might be feasible, if this proved to be the most appropriate course of action. In the event that contracts were transferred, there is no automatic assumption that the Boots stores involved will close."

Meanwhile, Boots Retail International (BRI) is closing 19 stores in Taiwan and Thailand and opening around 120 "implants".

Last week it confirmed it would shift its retail focus abroad from operating stand-alone stores to running concession stores within other retail outlets.

Boots Retail International will be locating about 100 "implants" in Watsons, Taiwan's largest drug store chain

The "implants" or "concessions" will be 20m²-60m² and carry 500-2,000 Boots lines. Boots said the model could potentially make operations in both countries profitable within two years.

"What we have now is a business model that can move into profit rather than a model that soaks up money," a Boots spokesman said.

BRI will close four of its 14 Taiwanese branches, while opening around 100 "implants" in the country's largest drug store chain, Watsons.

The roll-out is due to begin next month and is expected to be completed by early 2003. Boots will invest £2 million in the Taiwanese operations.

Also, 15 of the 67 Boots stores in Thailand are to be closed over the next six months. At the same time BRI is expanding the number of concession stores within the Tops supermarket chain to around 20 by the end of the year.

In each country Boots expects to incur asset write-offs of around £1.5m during the current financial year.

WHOLESALE

Phoenix gets cash injection

Phoenix Pharmahandel AG has received a cash injection of €70 million (£42.7 million) from its main shareholder, the Merckle family, even though its annual sales grew 35 per cent.

This brings the total invested in the business by its founding family over the past four years to €210m (£128m).

A spokeswoman for Phoenix said the extra resources provided a "financial cushion for future investments", and stressed that this did not indicate a cashflow problem.

PHOENIX
Pharmahandel Aktiengesellschaft & Co KG

While final figures have yet to be revealed, Phoenix's turnover will probably be around €11.5 billion (£7bn), based on last year's figures (2000: €8.6bn, £5.2bn).

The spokeswoman added that Phoenix expected its pre-tax profits to grow in double digits – last year they were €39.3m (£24m).

INDUSTRY

AZ buyback

AstraZeneca has extended its share buyback programme by $2 billion (£1.4 billion). The total buyback will be $2.4bn, as AZ has carried over $400 million of shares that it had not yet bought back from an earlier programme.

The latest buyback is expected to be completed by the end of 2003 and AZ intends to cancel all shares it purchases.

Meanwhile, AZ reported full-year sales of $16.5 billion (£11.7bn), an increase of 8 per cent. Its pre-tax-profits rose 7 per cent to $4.3bn (£3bn).

AZ warns that its sales this year could be broadly flat if a generic version of Losec is launched by the summer.

SURVEY

Pharmacy sales better than expected

Pharmacy sales in January have bucked the general trend and have exceeded expectations, according to the Confederation of British Industry's Distributive Trades survey.

Four in seven per cent of pharmacists said sales had increased in January compared with the same month a year ago, while 20 per cent reported a fall.

The resulting balance of plus 37 is well above expectations of plus 23. It is also 10 points ahead of last month's figure and broadly in line with the retail sector in general.

Only three pharmacists in the survey expect sales to fall in February, while 57 anticipate a rise – this would create a balance of plus 54.

Coming Events

FEBRUARY 11

Nottingham Branch, RPSGB
The Use Of OTC Medicines In Children In The East Midlands, by Sharon Conroy, lecturer in paediatric pharmacy, at the School of Pharmacy, Nottingham University, 7.30 for 8pm.

NICPPET
From Babies To Infants: The Role Of The Pharmacist, at the Everglades Hotel, Londonderry, 7.30 for 8pm.

NICPPET
From Babies To Infants: The Role Of The Pharmacist, at the Canal Court Hotel, Newry, 7.30 for 8pm.

FEBRUARY 12

NICPPET
Keynote lecture: *Rheumatic Disease: Rheumatoid Arthritis*, by Dr Aubrey Bell at the NICPPET Resource Centre, School of Pharmacy, Belfast, 8pm.

Bury & Rochdale Branch, RPSGB
The NHS Plan And Pharmacy In The Future, by Dr Gill Hawksworth, VP of RPSGB, at the Macdonald Norton Grange Hotel, Castleton, Rochdale, 7.30 for 8pm.

Moray & Banff Branch, RPSGB
NHS 24 with Debbie Jamieson of the NPA. Venue to be confirmed.

Oxfordshire Branch, RPSGB
Osteoarthritis: Prevention And Treatment, by Dr Matthew Brown, at the George Pickering Postgraduate Centre, John Radcliffe Hospital, 7.30 for 8pm.

FEBRUARY 13

NICPPET
Establishing A New Clinical Service, at the Fitzwilliam International Hotel, Antrim, 10am – 5pm.

FEBRUARY 14

Glasgow & Lanarkshire Branches, RPSGB
Why Is Glasgow An Unhealthy City And What Can We Do About It? by Dr Harry Burns, director of public health, GGHB, at SIBS 101, 27 Taylor Street, University of Strathclyde, 7.30 for 8pm.

FEBRUARY 15

NICPPET
Promoting Sexual Health, at the NICPPET Resource Centre, School of Pharmacy, Belfast, 10am - 5pm.

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Comment from the Editor

Three cheers for Scotland. Its Executive has produced its policy on pharmaceutical care and has set itself a timetable for completion (*pp4, 16-17*). Throughout the document are examples of the pilot schemes on which the strategy is based, with the slogan "It's already happening". With the phased implementation and the knowledge that what is proposed can be done, if not by everyone, pharmacists should not be deterred from taking on board the proposals.

Details of the costings, however, are not included. And that will be what SPGC, SPF and the RPSiS will want to examine. Without adequate funding, the strategy will not work.

Westminster also announced, or rather confirmed, some of its intentions for pharmacy on the same day (*p5*). The Government is making it clear that it wants to use pharmacy more, and is coming up with the prospect of real changes that could make the pharmacist's role more meaningful. Supplementary prescribing, repeat dispensing and ETP are now firm commitments for all. But the Scottish strategy launch also highlights the difference devolution can make. Scotland has been able to learn from the reactions to the English pharmacy programme and has tailored its policy accordingly. But if the Scottish pharmacy strategy has more of the good parts and fewer of the "problem" areas that England may be experiencing, there is a risk that a two-tier pharmacy service, and not just "equal but different" contracts, may develop.

Some serious is thought is now needed – not just on the Scottish document, but on changes planned by Westminster. Think about the changes you will need to make in your practice, and the resources you will need to make them, because it will become increasingly difficult to find an excuse not to in future.

There is a risk that a two-tier pharmacy service, and not just 'equal but different' contracts, may develop

Yourviews

Dr Ian Banks, from the Doctor Patient Partnership, examines POM to P moves

Switching: low incentives and more risks

GPs are concerned over the possibility that missed diagnoses, overdosing, inappropriate self-medication and poor continuity of patient notes may follow when medicines switch from POM to P.

Fair enough, but there is already a precedent to make the most fearful GP sleep soundly in his or her bed, or at least until the phone rings for a night visit. When ranitidine left the ranks of Prescription Only status there were genuine fears that gastric cancer would be missed and mortality rise as a consequence.

In fact, the death rate from stomach cancer has fallen, though we are not sure why. Could GPs be getting it wrong? Are we being far too paternalistic by not giving people credit for their own intelligence?

Readers in BMA House were [illegible] alarm when the pregnancy test first became freely available to women without the need to see their doctor. "These women need the support and advice of their doctor when given the results of such tests," they said.

Since then self-test kits for rectal cancer, prostate cancer, diabetes, cholesterol, even chlamydia, have appeared on pharmacists' shelves and it won't be long before people will be able to self-test for HIV, a major source of controversy for the medical profession. People are voting with their wallets and are quite sanguine about performing tests that were once the sole domain of the hospital lab with GP interface.

How does this impact on the POM to P switch? The list of drugs broadcast last week is longer than most GPs expected. It includes statins, sildenafil, beta-blockers and asthma preparations.

Trying to find some sort of generic switching system will be difficult as each has its own dangers and incentives for the major stakeholders. At a recent meeting hosted by the PAGB it became clear that incentives for industry to take part in switches were thin on the ground.

GPs may feel the same way. Protecting low-income groups from "'two tier access" to medicines is vital, otherwise the increased morbidity will mean more rather than less work for general practice. Incomplete medical notes also make for king-sized headaches not alleviated by the migraine preparations on the list.

Unwittingly prescribing nitrates for a patient already self-medicating on sildenafil never looks good in the GMC – or the *News of the World* for that matter – thus highlighting the issue of GP versus patient-held records. Indemnity also raises its head. Who is responsible for the drug-damaged patient? At least one statin manufacturer at the moment might have an opinion on this.

Inevitably it all comes down to unstoppable forces meeting immovable objects. Patient power is here to stay but something has to give; let's hope it is not the commitment to health and wellbeing.

HOSPITAL REPORT

Drifting in different directions?

Recent statements by the Health Secretary Alan Milburn highlight the gap that is opening up between NHS Scotland and the NHS in England. The suggestion that 35 English Trusts might be able to vary local terms and conditions would negate a lot of the advantages claimed for *Agenda For Change*.

Mr Milburn is also promoting this much-delayed plan for evaluating jobs in the NHS, ensuring they are proof against equal pay claims and producing a new national pay scale – yet pay harmonisation and local terms and conditions are mutually exclusive.

In Scotland, Health Minister Malcolm Chisolm made the point that it was an English initiative which has not been followed north of the border. Relations between NHS management, Government and staff appear to be much less confrontational in Scotland than in England.

The PPP contracts in Scotland have attracted a great deal of criticism in the press

England also appears to be much more involved in the new Public Private Partnerships. The PPP contracts in Scotland have attracted a great deal of criticism in the press. Bed losses, cost cutting and ludicrous restrictions have been blasted by the media.

The biggest rift between north and south came with the agreement of free personal care for the elderly in Scotland, though this appears to have been diluted with the change in administration within the Scottish Executive. First Minister Jack McConnell appears to be less enthusiastic on the issue, and some of the main recommendations of the *Sutherland Report* may be diluted or deferred.

The scale of the difference since devolution is considerable. What might it be like in 35 years time?

Contributed by a senior hospital pharmacist

TOPICAL REFLECTIONS

A radical POM to P solution – but is it acceptable?

The list of therapeutic groups considered suitable for treatment with reclassified "POM to P" medicines, published last week as a consensus document by the Royal Pharmaceutical Society, is truly radical. Not only is the list very extensive, but by concentrating on recurrent and chronic conditions it potentially puts community pharmacy in the forefront of a visionary NHS public/private partnership.

However, for this vision to be fully realised people have to be persuaded to take financial responsibility for their own health. This is a difficult task in an NHS where the culture of "free at the point of delivery" has become politically sacrosanct. I would be delighted to be given responsibility for managing and selling the range of medicines on the consultation list, but for many of the switches to be commercially successful, it would require changes to the principles of the NHS that I find unacceptable.

My euphoria has now been tempered by realism. I cannot see many chronic medical conditions being managed by the sale of P medicines but I can see the advantages of re-classifying many POMs to P to allow effective medicines to be bought for a wide range of recurrent problems.

A wonderfully cost-effective way of doing things

I received a phone call the other day from our local GP deputising service asking me to supply a prescription to a patient from a fax. There was nothing untoward in the request other than an analysis of the sequence of events after the incident.

I received two telephone calls, one from a receptionist and one from the locum doctor confirming the fax. I received the faxed prescription and the paper original by post. I dispensed the prescription, noted the exemption category and asked for proof. I advised the patient's representative how the drugs were to be used and then, when I received the original, completed the declaration as a proxy and at the end of the month submitted the prescription for pricing.

All in all, a laborious and costly process for a packet of 12 complete Migraleve tablets. The total cost to the NHS of this simple transaction must be enormous, yet could have so simply been dealt with by a simple statement from the doctor to the patient: "Go and buy a packet of Migraleve from your pharmacist."

Self-inflicted financial problems

Sometimes I am tempted to suggest that many of the financial problems that pharmacists face are self-inflicted. Last week I was picking up some prescriptions from our local surgery when a lady came in and asked the receptionist if the doctor would fill in an insurance form for her.

No problem! "It's £15 for half a page, £20 for a full page, and come back in seven days as he receives so many of these requests he cannot do them immediately." A nice little earner but expected and accepted without question by the lady.

Meanwhile, back in the world of pharmacy, debate still rages around the decision by Boots to charge a pittance for filling domiciliary MDS cassettes. Not only should Boots charge, but it should also immediately start charging for nursing and residential homes as well, and increase those charges to financially viable levels.

After my experience in the surgery I have decided to charge a fee for all my services and have produced a price list: £10 for a passport, £5 for a driving licence, £10 for a firearms licence, £5 per month per MDS cassette filled, and £10 per requested delivery. I wonder if Boots will follow my lead?

The benefit of the doubt

I try to check proof of exemption claims by patients, but invalidity benefit has always confused. Now, thanks to the National Pharmaceutical Association and this month's *Supplement*, I am much wiser.

Invalidity benefit does not entitle patients to free prescriptions, even though they are able to flourish one of those universal benefit payment books. I have cut out the item from the *Supplement* to prove this and stuck it to the bottom of the prescription tax notice in front of the dispensary. Hopefully that should now be the end of many an argument!

Royal Pharmaceutical Society in Scotland chairman, Alison Strath, discusses the strategy with Scottish Executive health minister Malcolm Chisholm in the Inch Pharmacy, Edinburgh

The Scottish pharmacy strategy *The Right Medicine: a Strategy for Pharmaceutical Care* puts into policy much of what has already been tried and tested

It's happening alrea

"If community pharmacy contractors are to deliver then we will undoubtedly require considerable financial support"

Overall, the Scottish pharmacy strategy unveiled on Monday should contain few surprises.

In essence it puts into one policy document much of the good work that has been piloted in Scottish pharmacy settings, and elsewhere. A timetable sets out a four-year plan which should make the strategy achievable in "bite-size" pieces; and chief pharmacist Bill Scott hopes that pharmacists will see the changes that are happening not as a threat, but something that they can all work towards.

Among the commitments are that pharmacists will see a greater utilisation of their skills; money is to be made available to help update pharmacy premises to incorporate consultation areas; and pharmacies will be used more in a health and social care awareness role.

A new national contract is also proposed, but lurking with it is a commitment to introducing local pharmaceutical service schemes. There are concerns south of the border that LPS may be supplied by people or organisations other than pharmacists. However, in Scotland, the strategy states that the Scottish Executive will seek powers to enable NHS Boards to contract directly with community pharmacy contractors for the provision of additional services. Still, with an implementation date of December 2005, Scotland will be able to learn from the English experience.

Workforce planning needs to be scrutinised, though. The strategy talks about redesigning services as well as looking at better out-of-hours pharmaceutical provision. This might be intimidating, but as the strategy is for the whole of pharmaceutical provision within NHS Scotland, there might well be more collaboration between the hospital and community sector, as well as those currently working as primary care pharmacists.

On this point, the strategy seems to echo Mr Scott's comments last year about pixies and pixels, and how the pharmacy workforce should be employed. The strategy points out that PCTs and LHCCs employ pharmacists to help GP practices for a variety of advisory, budgeting and prescribing control purposes.

"It is important that pharmacists located in GP surgeries are integrated into local community and hospital pharmaceutical services to ensure continuity of care"

"This work is very valuable," says the strategy. "However, pharmacists and technicians are a scarce resource to NHS Scotland; therefore there is a need to explore alternative ways of undertaking some of these functions.

"It is important that pharmacists located in GP surgeries are integrated into local community and hospital pharmaceutical services to ensure continuity of pharmaceutical care."

The Royal Pharmaceutical Society in Scotland has "warmly welcomed" the strategy. RPSiS chairman Alison Strath thinks that: "While it's quite ambitious, it is achievable." A lot of what is in it is already happening, she says: "We have lots of pockets of great practice, but they are not standard or across the board." The strategy will help change this.

For her, one of the key driving forces will be the repeat dispensing model. This will help lay down the process framework on which the quality measures can be built, she believes.

This strategy also means: "Pharmacists are centre stage but they are there alongside other health practitioners and social care providers. The more we work in a joined up way, the better we provide those services."

Ms Strath is pleased to see the commitment to health promotion through community pharmacies – "an untapped resource for public health. Pharmacists are hands-on public health practitioners," she says, "but in the past pharmacists have been forgotten and not built into campaigns.

"The public health aspect is something we can build on very strongly," she emphasises, pointing out that Scotland has pharmaceutical public health specialists. She anticipates pharmacists will be spending more time working with others, not just health practitioners, but also those in the social care environment.

In terms of improving access to medicines, Scotland has already been piloting pharmacist prescribing in Arbroath and Patna. Pharmacists are treating common illnesses on the NHS with OTC medicines and by supplying POMs under patient group directions.

It is also important that pharmacy premises are fit for the purpose, so a further tranche of cash for modernising pharmacies

***The Scottish Pharmaceutical Care Strategy:* sets much of what's happening already in schemes in Scottish pharmacies**

to include consultation areas has been made.

Money allocated for this has been welcomed by Scottish Pharmaceutical General Council chairman Frank Owens. "If community pharmacy contractors are to deliver, then we will undoubtedly require considerable financial support. I am encouraged therefore by the health minister's announcement of the provision of a £4 million fund to support the initial stage of implementation of the strategy over the period 2002/03."

He, too, welcomes the strategy's recognition of the "significant potential for community pharmacy to extend its role, both as a gateway to and provider of NHS primary care services".

There is an emphasis on pharmacy service provision in deprived communities, whether inner city or rural. But unlike England, the Scottish plans shy away from building new one-stop walk-in health centres, and concentrate instead on making the most of the existing pharmacy network.

On this, he echoes Ms Strath's views on the need to keep the pharmacy network. Pharmacists counter prescribe every day and could augment their activities within agreed protocols, making the entire process easier for patients and at the same time easing the burden on GPs and practice nurses, he suggests. In a reconfigured Scottish primary care service there is no need for expensive walk-in centres, such as can be found in other areas of the UK. Instead, there is potential to redesign some pharmacies to share them with other health professionals and social workers, working side by side with pharmacists.

Despite reassurances to the contrary, it is still likely that pharmacists will wonder how out-of-hours services can be strengthened. Presumably the existing out-of-hours provision will have to be examined to see what is working well and what is not, and then seeing how the commitment can be delivered.For any changes to be made it will probably be necessary to use pharmacists in a variety of settings, not just the community.

Out-of-hours is one issue that has been identified by the Scottish Pharmaceutical Federation as needing further analysis. SPF chairman Ian Johnston has welcomed the additional money for consultation areas, but warns that a full assessment of the impact of the strategy will only be possible after detailed examination. He anticipates there will be extensive discussions with the Scottish Executive over the content and funding implications. "An enhanced role for community pharmacists, for example the introduction of more flexible arrangements to allow people access to community pharmacy services after normal hours, would have to be costed."

Outreach work, for example in care homes, may also see community pharmacists working with nurses and carers. But the matter of the pharmacist leaving the dispensary to visit the home will still need to be addressed. Hence, there may be a need for greater involvement of peripatetic pharmacists, for example primary care pharmacists, although it will be important to ensure that any such outreach services are provided through community pharmacies.Accessing medicines is a key strategy for the UK Government, and also for the Scottish Executive. The Scottish strategy sends a strong signal that there will be a need for pharmacy input. For example, the fact that nicotine replacement therapy is to be made available free on the NHS through pharmacies means patients are able to access medicines themselves, without having to wait for a prescription.

While some of the initiatives will require additional training, Ms Strath believes: "There's no reason why any practising community pharmacist should not be able to manage a repeat dispensing service."

But with the pharmacist shortage across the UK, can there be any guarantee that there will be enough pharmacists to implement the Scottish plan, or might they be attracted to other countries? The strategy may be attractive to pharmacists, but will be judged by whether it gives them a more meaningful role, she suggests.

Mr Scott has anticipated that there will be a need to keep pharmacists engaged in the process. To keep them motivated, now and in the future, he stresses that post-qualification training should be encouraged.

His introduction to the strategy says that pharmacists' education and training needs strengthening. There also needs to be an infrastructure put in place "which supports career development and encourages a systematic and evidence-based culture". To this end the strategy advocates the establishment of multi-disciplinary learning and the consideration of "professional doctorates", which would produce research professionals in a practice setting. These could provide further evidence-based clinical practice in both primary and secondary care.

One word of caution though, to the RPSGB – Scotland is now committed to supporting the "early implementation of a compulsory obligation for pharmacists to undertake and document their CPD as a requirement for their registration to practice". Although this has the longest deadline of December 2005, it is to be hoped that CPD is taken on board by the profession much earlier.

For more information:
http://www.scotland.gov.uk/pages/news/2002/02/SE5292.aspx

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References:

1. Spruance SL. Seminars in Dermatology 1992; **11**(3): 200-206. 2. Data on file, GlaxoSmithKline, 1999.

Fawz Farhan, visiting lecturer in pharmacy at King's College, London, continues her Body Basics physiology series with a look at the respiratory system

Breathing space

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Objectives

After reading this article you should be able:

- To revise the structure of the respiratory system
- To understand gaseous exchange
- To understand how the blood's pH is balanced
- To revise respiratory function terms
- To revise the factors controlling breathing

The respiratory system has three functions: the exchange of gases between the atmosphere and the cells of the body, maintenance of pH balance of the blood, and vocal expression.

The true definition of respiration is the uptake of oxygen from the atmosphere and its delivery to the cells of the body, the removal of carbon dioxide from the cells and its excretion into the atmosphere.

Respiration has four stages:

- **Pulmonary ventilation** – commonly known as breathing, that is the inspiration and expiration of air. This mechanism allows the exchange of air between the atmosphere and the air sacs of the lungs.
- **Diffusion and gas exchange in the lungs** – this includes the passage of oxygen from the lungs into the blood and the passage of carbon dioxide from the blood into the lungs.
- **Transport** – which refers to the circulation of gases in the blood and the transport of gases from the lungs to the cells and vice versa.
- **Cellular respiration** – the uptake of oxygen from blood into the cells where it is used to break down nutrients and release energy. At the same time carbon dioxide, the by-product of this process, is released by the cells into the blood for transport back to the lungs. This was covered in the Metabolism article in this series (*C&D, December 8, 2001, p25-28*).

The first three stages will be discussed in detail later. To get a better understanding of the physiology and function of the respiratory system, it is important to look at its basic anatomy first.

Anatomy

The respiratory system consists of a set of cavities and passageways that lead air into the lungs from the atmosphere and back out again. The main structures are nasal cavities, pharynx and larynx, trachea and lungs

Nasal cavities

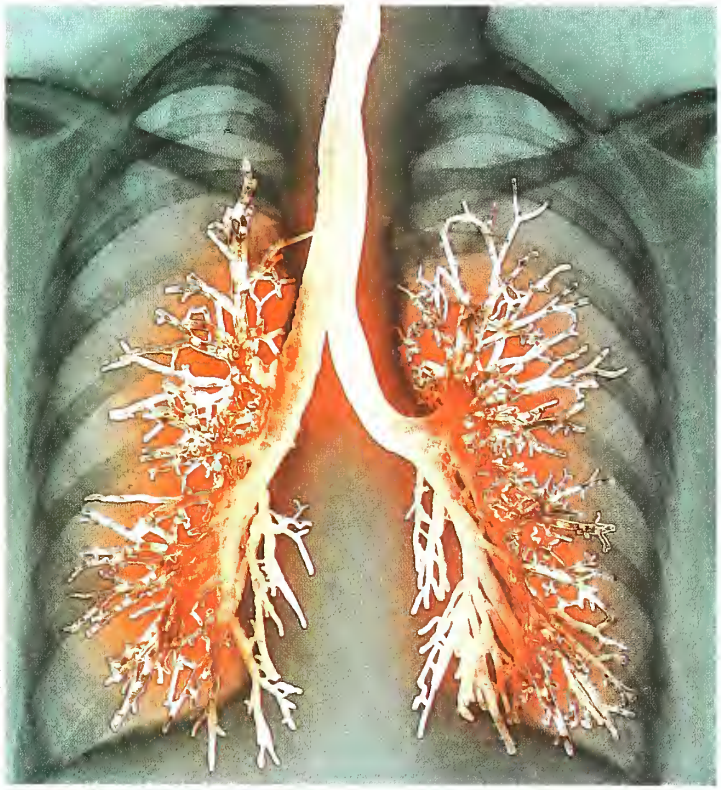
Air is drawn in from the environment through the nostrils and into the nasal cavities between the roof of the mouth and the cranium. The nasal cavity, which is divided in two by the septum, is composed of intricate, shell-like structures that increase the surface area over which the air passes. This cavity is also lined with a mucous membrane, which maintains a warm, moist environment.

The nasal cavities have a protective function. They remove foreign particles and pathogens by means of the tiny hairs in the nostrils and by the mucus produced by the nasal cavities. They also warm and moisten the air before it reaches the lungs.

These protective functions occur only when breathing through the nose. Breathing through the mouth rather than the nose therefore has its disadvantages.

Pharynx and larynx

The pharynx (throat) is shared by the respiratory system and the digestive system. Its function in the respiratory system is to carry air from the nasal cavities down into the larynx and trachea.



Inner Space Imaging/Science Photo Library

Chest x-ray showing the airways (red) of the lungs. The trachea divides into two main bronchi. The bronchi then split further into smaller bronchi and finally bronchioles that terminate at clusters of alveoli (not seen)

The epiglottis covers the larynx during swallowing to stop food and drink going down into the airways.

Trachea

This is also called the windpipe and leads air from the pharynx into the lungs. Along its length are C-shaped rings of cartilage which keep the trachea open and stop it from collapsing. The open end of the rings back onto the oesophagus, allowing food to bulge out as it goes down into the stomach.

Lungs

The two lungs in the thorax are separated from the abdominal cavity by the diaphragm, a horizontal muscle wall. Each lung is enclosed in a protective double sac called the pleura.

The lungs specialise in diffusing gases between the air that is taken in from the atmosphere and the blood. The trachea subdivides into two bronchi and one enters each of

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Continued from page 19

Respiratory function can be measured using a spirometer – the patient breathes in and out of an air-filled container and a trace records the volume breathed. (Average volumes are listed below after each measure).

- **Tidal volume:** volume of air moving in and out of the lungs at rest (500ml).
- **Residual volume:** volume of air remaining in the lungs after maximum exhalation (1200ml).
- **Vital capacity:** volume of air that can be expelled after maximum inhalation (4800ml).
- **Total lung capacity:** total volume of air that the lungs can hold after maximum inhalation (6000ml).
- **Functional residual capacity:** volume of air remaining in lungs after normal exhalation (2400ml).
- **Minute volume:** volume of air breathed per minute. It is the tidal volume multiplied by the respiration frequency.
- **Forced expiratory volume:** volume of gas expelled from the lungs over a timed period when a patient makes a maximal expiratory effort after a full inspiration.
- **Peak expiratory flow rate:** maximal flow that can be sustained over 10 milliseconds during a forced expiration after total lung capacity. This is measured using a peak flow meter.

the lungs. Inside the lungs the bronchi divide into secondary bronchi and bronchioles forming a tree-like network of air vessels. The bronchioles have no cartilage and are mainly composed of smooth muscle controlled by the autonomic nervous system.

The minute, hair-like bronchioles – called the terminal bronchioles – end in alveoli. These are clusters of air sacs, composed of a single-cell epithelium layer, which are enclosed in a network of blood capillaries. There are millions of alveoli in the lungs and so they offer a high surface area for gas exchange, equivalent to around 60m^2, which exceeds normal needs.

Some cells in the alveoli produce a surfactant, which reduces the surface tension of the mucus and fluid lining the alveoli and stops the alveoli collapsing.

Cilia

The bronchi and other conducting passageways of the respiratory tract are lined with cilia which, together with mucus, help sweep impurities and pathogens away from the lungs towards the throat where they can be eliminated by coughing, sneezing or blowing the nose.

Function

Pulmonary ventilation refers to the normal process of breathing and involves inhalation and exhalation.

Inhalation: this is the active phase of breathing. The intercostal muscles contract to expand the thoracic cavity and draw air into the lungs. At the same time, the diaphragm contracts and flattens, pushing the abdominal organs down – again expanding the thoracic cavity.

All this results in the gas pressure within the cavity falling below atmospheric pressure, resulting in air being sucked in. The elastic tissues of the lungs, aided by surfactant, expand easily in response to this pressure. The ease with which they expand is called compliance. Factors that hinder this include diseases that damage the lungs, scar tissue, fluid accumulation, deficiency of surfactant and damage to the muscles involved in breathing.

Exhalation: this is the passive phase of breathing. The respiratory muscles and the diaphragm relax, decreasing the space and pressure in the thoracic cavity. At the same time, the elastic tissues of the lungs recoil. All this results in the air being expelled into the atmosphere.

The cycle of inhalation and exhalation mixes the air in the lungs so that the gases in the alveoli stay fairly steady and there is little overall change in the oxygen and carbon dioxide composition. However, the continuous breathing process ensures that oxygen and carbon dioxide are exchanged adequately.

Gas exchange and diffusion

Inspired air from a dry atmosphere contains around 21 per cent oxygen, 0.04 per cent carbon dioxide, nitrogen and traces of other gases (79 per cent) and negligible water vapour. Moisture is added as air travels down the respiratory tract, changing the composition. Expired air contains nearly 15.7 per cent oxygen, 3.6 per cent carbon dioxide, nitrogen and traces of other gases 74.5 per cent, and 6.2 per cent water vapour.

For gases to diffuse through the alveoli, they have to be in solution and so a moist environment is crucial. Two-way diffusion occurs in the lungs.

The pulmonary circuit feeds the lungs with blood and allows for oxygenation of blood and elimination of carbon dioxide. These capillaries are fed with deoxygenated blood from the pulmonary artery. When the capillaries reach the alveoli, carbon dioxide diffuses out of the blood, through the alveolar wall and into the air sacs, to be expired by the lungs. At the same time oxygen from the inspired air diffuses into the blood capillaries feeding the alveoli; the oxygenated blood is carried to the pulmonary vein to the rest of the body.

Transport

Once oxygen has diffused through the alveolar wall into the capillaries it is mostly bound to the haemoglobin of the red blood cells, with a small percentage carried in the plasma.

Blood in the systemic arteries and pulmonary veins is 97 per cent saturated with oxygen. This drops down to 70 per cent in the systemic veins and pulmonary arteries, the percentage difference representing the proportion of oxygen taken up by the tissues during transport.

Once the blood reaches the cells, oxygen breaks away from haemoglobin and passes into the cells. At the same time carbon dioxide, a waste product of metabolism, passes out of the cells into the surrounding blood capillaries. About 70 per cent of the gas is transported as bicarbonate ion in the plasma, 20 per cent is combined with blood proteins and 10 per cent is carried as a solution in the plasma and fluid in the red blood cells.

Carbon dioxide is responsible for regulating the pH or acid-base balance of the blood. When carbon dioxide dissolves in plasma and forms bicarbonate, a hydrogen ion is also released which contributes to the acidity of the plasma.

Therefore the more carbon dioxide in the blood the higher the acidity. When carbon dioxide is

Continued on page 22

Common respiratory disorders

Infections

The respiratory tract is open to the environment and is therefore susceptible to infection by pathogens. These are usually carried in droplets from sneezing or coughing. The mucous membranes and cilia offer some protection but this is not always enough, particularly if there is local damage or resistance is low. Infections commonly carried through the respiratory tract include the common cold, influenza, diphtheria, chicken pox, measles, pneumonia and tuberculosis.

Hayfever, rhinitis

Seasonal and perennial allergic rhinitis are triggered by allergens such as pollen or dust. Common symptoms are watery eyes and nose.

Asthma

Asthma refers to the reversible inflammation of the airways and the spasm of the involuntary muscles of the bronchioles. This leads to constriction of the airways and obstruction of airflow into the lungs. Asthma may be triggered by allergens such as house dust mites and cold air.

Chronic obstructive pulmonary disease (COPD)

This includes chronic bronchitis and emphysema. In the first, the linings of the airways are chronically inflamed and are congested by excess secretions. Emphysema is characterised by dilation and destruction of the alveoli.

COPD results in obstruction of normal airflow and impaired respiratory function. Smoking is a common cause of COPD.

Pleurisy

This refers to inflammation of the pleura and accumulation of fluid in the pleural space. Causes include heart failure, hepatic or renal impairment, infection and oedema. Pleurisy is recognised by sudden sharp chest pain which is worse on movement or breathing. Treatment focuses on the underlying cause.

Corsodyl has one successful ingredient not found in any other chlorhexidine gluconate mouthwash.

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The bottom line is that you and your customers can trust it to work. And its superior taste[1] also encourages better patient compliance, which is good news for everyone and another reason why Corsodyl is still the best selling medicated mouthwash in Pharmacy.[2]

So the next time a customer needs treatment for gum disease, make sure you give them Corsodyl – and only Corsodyl.

Corsodyl is a registered trademark of GlaxoSmithKline group of companies

Corsodyl. **Uses:** Inhibition of plaque; treatment and prevention of gingivitis, maintenance of oral hygiene; promotion of gingival healing following surgery; useful in the management of aphthous ulceration and oral candidal infections. **Presentation:** Mint Mouthwash: Clear colourless solution containing 0.2% w/v chlorhexidine gluconate. Mouthwash: Clear pink solution containing 0.2% w/v chlorhexidine gluconate. **Dosage & Administration.** Mouthwash and Mint Mouthwash: Rinse mouth with 10ml undiluted for one minute twice daily. Prior to dental surgery, rinse mouth with 10ml for one minute. **Contraindications:** Previous hypersensitivity reaction to chlorhexidine. Such reactions are, however, extremely rare. **Precautions:** For oral use only, keep out of eyes and ears. **Pregnancy & Lactation:** No adverse events have been reported, and no special precautions are recommended. **Side effects:** Occasional irritative skin reactions. Extremely rarely, generalised allergic reactions to chlorhexidine. Superficial discoloration of the tongue, teeth and tooth-coloured restorations may occur, usually reversible. Transient taste disturbances and burning sensation of the tongue may occur on initial use of the mouthwash, usually diminishing with continued use. Occasional oral desquamation. Very occasional parotid swelling. **Overdosage:** Systemic effects are unlikely after accidental ingestion of overdose, however gastric lavage may be advisable. **Product Licence Numbers and Basic NHS Costs:** 'Corsodyl' Mouthwash (0079/0313) 300ml (OP) £1.93 'Corsodyl' Mint Mouthwash (0079/0312) 300ml (OP) £1.93 600ml (OP) £3.85. **Legal Category** GSL. Date of last revision September 2001. **Licence Holder:** Mint and Original Mouthwash GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS. Source: [1]GlaxoSmithKline data on file 1998. [2]IRI Data total market value sales Jan 01.

Professor P Motta, Dept of anatomy, University of La Sapienza, Rome/Science Photo Library

Tracheal epithelium: false-colour scanning electron micrograph of the ciliated epithelium lining the trachea, the windpipe

◀ *Continued from page 20*

expelled into the lungs, the acid-base balance shifts back towards alkaline. Bicarbonate also acts as a buffer in the blood helping to keep the body fluids at a pH of 7.4.

Regulation

An adult normally takes in 12-20 breaths a minute; in children the rate varies according to age and size but is usually between 20 and 40 breaths a minute.

Respiration is controlled by the nervous system and a chemical system. These two systems work together to ensure that the level of oxygen is maintained even when the body's oxygen needs change, such as during exertion or high metabolic activity.

Nervous control

The respiratory control centre is located in the medulla and brain stem. This centre controls the basic breathing pattern and modifies it when necessary to keep the levels of oxygen, carbon dioxide and acid within normal range.

Motor neurons – which extend from the brain, through the spinal cord and into the diaphragm – enable the brain to control respiration involuntarily. Breathing can also be controlled consciously by the brain's cortex, for example, by holding one's breath or deliberately breathing in more slowly.

Chemical control

Working alongside the nervous system are chemoreceptors that regulate respiration by taking dipstick readings of the blood at various points in the body.

The respiratory chemoreceptors are found outside the medulla and brain stem, and near the carotid arteries in the neck and the aortic arch. These detect increases in carbon dioxide and hydrogen ion (acidity) levels (and hence decreases in oxygen levels) and trigger an impulse to the brain to increase the rate of respiration.

Because there are usually oxygen reserves in the body, carbon dioxide is the main chemical controller for respiration. However, when oxygen levels fall well below normal levels oxygen becomes the controlling factor.

Hyperventilation and hypoventilation

These are abnormalities linked to the regulation of respiration.

Hyperventilation normally occurs as a result of anxiety and is characterised by deep and rapid respiration. This results in oxygen levels rising and carbon dioxide levels falling, which increases the blood pH and leads to symptoms of alkalosis, such as dizziness and tingling. Eventually, the person stops breathing because there is insufficient carbon dioxide to stimulate the respiratory control centre. This then automatically raises carbon dioxide levels and returns the body to its normal pattern of breathing. Breathing into a paper bag has the same effect and is often recommended in this condition.

Hypoventilation occurs when insufficient oxygen enters the alveoli, for example as a result of lung disease or drugs, and leads to a rise in carbon dioxide levels and acidosis.

Actionplan

1. Revise the devices that can be prescribed on the NHS to measure respiratory function. Why are there different specifications for them?
2. Make sure you know how to operate a peak flow meter. Prescribers sometimes do not instruct their patients when to take readings. Consider what you would tell such a patient.
3. Revise your knowledge of emphysema, chronic bronchitis and asthma. List their similarities and differences. Also note treatments.
4. List the primary symptoms of pleurisy in your workbook. Can you distinguish between pleurisy and intercostal muscle pain?
5. Revise the stepwise management of asthma as shown in the BNF. Do you think the majority of patients with chronic asthma using your pharmacy are being treated most appropriately? Record in your practice workbook examples of patients who appear to be treated less than optimally. Should you discuss these patients with the prescriber? If not, why not? Should you provide domiciliary oxygen? In your practice workbook list the pros and cons.
6. Find out what devices are available to reduce sleep apnoea. If patients want advice on such devices, to whom should you refer them? Can the devices be prescribed on the NHS through pharmacy?

Common terms relating to abnormal or inadequate breathing

- **Apnoea** – temporary cessation of breathing which can occur during sleep.
- **Dyspnoea** – difficult or laboured breathing.
- **Hyperpnoea** – abnormal increase in the depth and rate of breathing.
- **Orthopnoea** – breathlessness relieved by assuming a more upright posture, for example, sitting or propping up more pillows when lying in bed.
- **Tachypnoea** – rapid breathing, maybe as a result of exercise.
- **Cyanosis** – bluish colouring of the skin from insufficient oxygen in the blood.
- **Hypoxia** – lower than normal levels of oxygen in the tissues.
- **Hypoxaemia** – lower than normal levels of oxygen in arterial blood.
- **Suffocation** – cessation of breathing, usually caused by mechanical blockage of the respiratory passages.

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice questionnaire (MCQ) paper to be inserted in the March 2 issue, which will cover this week's CPP-accredited module, together with that appearing in the February 23 issue.

- **Respiration (1226)** ● **Multiple myeloma (1227).**

The marking service offers independent verification of results – details on the monthly MCQ papers. Anyone wishing to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

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Nytol Herbal is back on TV.

In the jungle it's all about survival of the fittest. And it's no different in business. At 29%, Nytol Herbal's value share is already growing[1] but we aim to grow it faster. That's why we're back on national TV spending just under £1 million this Spring alone. Make sure you keep the entire Nytol range in stock and on display. **Good mornings follow a good Nytol**

Nytol & Nytol One-A-Night: **diphenhydramine.** Nytol Herbal: **hops, dogwood Jamaica, wild lettuce, passiflora, pulsatilla.**

NYTOL NIGHT TIME HERBAL SLEEP AID. Product Information. Presentation: Tablets, each containing: Hops 3:1 mg; Dogwood Jamaica 90mg; Dry Extract of Wild Lettuce 5=1 54mg; Dry Extract of Passiflora 5=1 36mg; Dry Extract of Pulsatilla 3=1 15mg. **Uses:** A traditional herbal remedy to promote calmness and natural sleep. **Dosage and administration:** Two tablets at bedtime. Not recommended for children. **Contraindications:** None known. **Precautions:** Keep all medicines away from children. If symptoms persist, seek medical advice. Not recommended in early pregnancy and lactation. **Side effects:** None known. **Legal category:** GSL. **Product licence number:** 00250/0005R. **Product Licence Holder:** Potter's (Herbal Supplies) Ltd, Wigan WN1 2SB. **Further information is available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, UK. **Package quantity and RSP:** £4.49 for 28 tablets. **Date of last revision:** January 2002.

NYTOL AND NYTOL ONE-A-NIGHT. Product Information. Presentation: Nytol: White uncoated oblong caplets imprinted with an "N", each containing 25mg of Diphenhydramine Hydrochloride BP. Nytol One-A-Night: White coated oblong caplets imprinted with "N50", each containing 50mg of Diphenhydramine Hydrochloride BP. **Dosage and administration:** Two 25mg caplets or one 50mg caplet to be taken orally 20 minutes before going to bed, or as directed by a physician. Not recommended for children under 16 years. **Uses:** An aid to the relief of temporary sleep disturbance. **Contraindications:** Hypersensitivity to diphenhydramine, asthma, narrow angle glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction or bladder neck obstruction. **Precautions:** Nytol and Nytol One-A-Night are not recommended during pregnancy or for lactating mothers. Concomitant use with alcohol, other hypnotics, sedatives, tranquillizers or monoamine oxidase inhibitors should be avoided. Nytol and Nytol One-A-Night should be used with caution in patients with myasthenia gravis or seizure disorders. Nytol and Nytol One-A-Night produce drowsiness/sedation soon after dosing and will affect ability to drive/use machines. Tolerance may develop with continuous use. **Side effects:** Dizziness, drowsiness, grogginess, dryness of mouth, nausea and nervousness. Antihistamines have been reported rarely to cause thrombocytopenia. **Legal category:** P **Product licence number:** Nytol: 00036/0050. Nytol One-A-Night: 00036/0069. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** Nytol: £2.75 for 16 caplets. Nytol One-A-Night: £4.15 for 16 caplets. **Date of last revision:** January 2002. Nytol is a registered trademark of the GlaxoSmithKline Group of Companies. Reference: IRI [illegible] 01

gsk GlaxoSmithKline

The antibiotic dilemma

Researchers argue for more investigation to clarify a link between falling antibiotic prescriptions and rising pneumonia deaths. *Joanna Lumb* looks at the problem

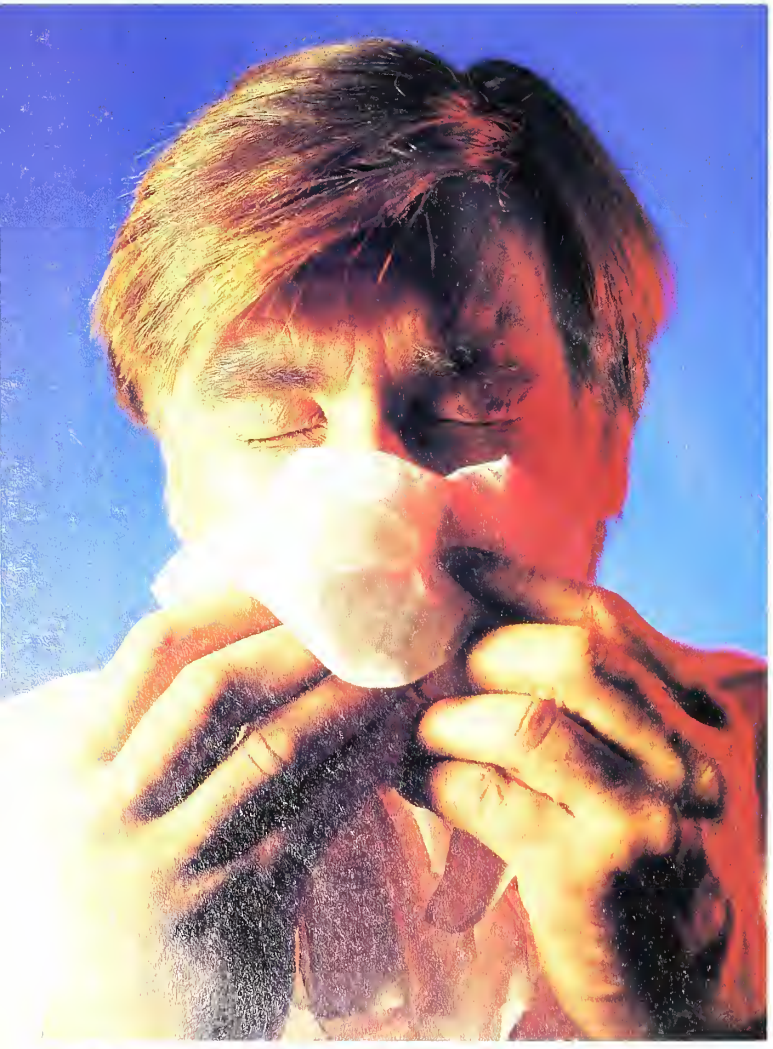
Acute respiratory tract infection is the most frequent presenting complaint in general practice. For such a common problem, evidence to guide prescribing is surprisingly limited.

Apart from general agreement that antibiotics are not needed for simple coughs and colds, and are urgently needed in community-acquired pneumonia (CAP), there is little definite evidence about which patients need antibiotic treatment.

The dilemmas GPs face are in distinguishing between pneumonia and milder conditions, and deciding which patients with self-limiting infection might still benefit from an antibiotic.

Dr Mike Thomas, a GP in Minchinhampton and research fellow, University of Aberdeen, identifies three main reasons why a GP might prescribe antibiotics for a chest infection:

- patient expectation (possibly less common nowadays)
- a wish to speed recovery of self-limiting illness
- anxiety not to miss a serious illness.



Is this a cold or could it be the start of something more serious? This is the diagnostic problem which faces most GPs daily

Diagnostic difficulties

Use of antibiotics to speed recovery is controversial, he says. "Although the majority of patients with respiratory infections will get better without antibiotics, these infections can cause prolonged morbidity and patients might get better more quickly if given an antibiotic. But we just don't know. The research evidence is limited and conflicting."

More important is the risk of missing serious illness. CAP is a common condition, associated with significant mortality. It is three times more common in patients aged over 60 than in younger patients, and risk of mortality is higher in the elderly and in those with co-morbidity.

Pneumonia is notoriously difficult to diagnose in the community, says Dr Thomas. In hospital, diagnosis is easy with a chest x-ray, but this is not generally available to GPs.

Clinical examination of the chest may find signs indicating pneumonia, but their absence does not mean that the patient does not have pneumonia on that day or the next.

"All GPs worry about missing such a condition. Current evidence is not sufficient to enable us to target accurately those who do and those who don't need antibiotics," he says.

Increased mortality

New evidence-based guidelines from the British Thoracic Society on management of CAP in adults emphasise that distinguishing CAP from other causes of respiratory symptoms and signs can be particularly difficult in patients with co-morbidity, such as heart failure or chronic obstructive pulmonary disease (COPD).

Recent campaigns to reduce unnecessary GP prescribing of antibiotics, because of fears of increasing bacterial resistance, have had a marked effect. However, new research has raised the question of whether the 25 per cent drop in overall antibiotic prescriptions and even more for lower respiratory tract infections (LRTI) is having adverse effects.

The research, presented at the BTS winter meeting, suggested that the fall in prescribing might be associated with an increase in deaths from CAP.

The researchers analysed prescribing data and pneumonia mortality data for England and Wales between 1995/96 and 1999/00. They found that winter antibiotic prescriptions for LRTI fell by 35 per cent while pneumonia mortality increased by 50 per cent.

The incidence of flu had the greatest effect on pneumonia mortality, but after correcting for the effects of flu there was still a statistically significant association between reduction in antibiotic use and pneumonia deaths, equating to one death from CAP for every 200 fewer antibiotic prescriptions for LRTI.

Cause and effect is not proven – but the researchers believe more investigation of the results is needed to allow better antibiotic prescribing.

Which antibiotic?

Having decided to prescribe an antibiotic, which drug should the GP choose? For CAP, the new guidelines say amoxicillin remains the drug of choice, but at a higher dose (500mg to 1g tds) than previously recommended. Erythromycin and clarithromycin are alternatives.

Ms Jane Moffatt (pharmaceutical adviser, Brighton and Hove PCG) says most primary care organisations now have local guidelines on management of common infections, giving advice on when to use antibiotics and appropriate first and second line drugs.

She says community pharmacists can be involved in guideline development, but should do this by working with the PCO, so that views of local microbiologists and hospital specialists are included.

Ms Jane Brown (prescribing adviser, North Manchester PCT) suggests that community pharmacists can work with local GP practices in educating patients about antibiotics.

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Northern Ireland pharmacists enrolling for Update before the end of February will have their registration fee paid by the NI Centre for Pharmacy Postgraduate Education and Training.

Just complete the coupon and send it with a cheque for £20.00 (£17.02 + VAT). Alternatively, call Mary Prebble on 01732 377269 with your credit card details. This will register you for 12 months' worth of certificated marking. After February 16, the standard registration fee for Update will be £25.00.

For further information, contact Mary Prebble on 01732 377269.

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Send this completed form to: Mary Prebble, Pharmacy Projects, CMP Information, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW.

Scriptlines

Once-a-day timolol gel

Novartis has launched Nyogel (timolol) 0.1 per cent eye gel. It is indicated for the reduction of elevated intraocular pressure in ocular hypertension and in chronic open-angle glaucoma.

The recommended dosage is one drop in the affected eyes daily, preferably in the morning. The eye-drop bottle must be held vertically to ensure correct dosing.

Ocular side effects include irritation, blurred vision of short duration and dry eyes. Systemic effects include bradycardia, hypotension, Raynaud phenomenon, bronchospasm, fatigue and headache.

Novartis says that systemic absorption is reduced by 90 per cent when Nyogel is compared to timolol 0.5 per cent eye drops.

Price: £2.85

Pack size: 5ml
Pip code: 285-1012
Novartis Pharmaceuticals
Tel: 01276 692255.

Frontshop

Clearasil gets ready to launch triple spot attack

Crookes will launch three products in the Clearasil range in March. Updated packaging and a £4.2 million promotional campaign will back the launch.

The latest variants in the Clearasil Complete range are Pore Purifying Wipes, Instant Effects and Overnight Defence Gel.

Pore Purifying Wipes remove dirt and grease, unblock pores and fight bacteria to help keep spots at bay. The wipes, which are in a resealable pack, contain antibacterials and alphahydroxy acids. They can also be used to remove make-up.

Instant Effects is designed to be used on spots as soon as they appear. Packaged in a metallic rollerball, it contains glycolic and tannic acids to unblock pores and fight bacteria.

Overnight Defence Gel is targeted at teenagers who find that spots appear first thing in the morning. The product, which contains triclosan and salicylic acid to unblock pores and treat bacteria, should be applied before going to bed.

The blue, silver and red packaging will be updated in March into a more modern look.

Television advertising for the Clearasil brand began this week and lasts until March 10.

Point of sale material includes display stands and a pharmacy assistant product recommender, which will be delivered to shops from March 15 by territory managers.

Crookes has also suggested a core range of products that pharmacies should stock.

Price: Wipes £4.29, Instant Effects £4.49, Defence Gel £4.49

Pip code: Wipes 284-8596, Instant Effects 284-8588, Gel 284-8602
Crookes Healthcare
Tel: 0115 953 9922.

Cough, cold & flu FORECAST

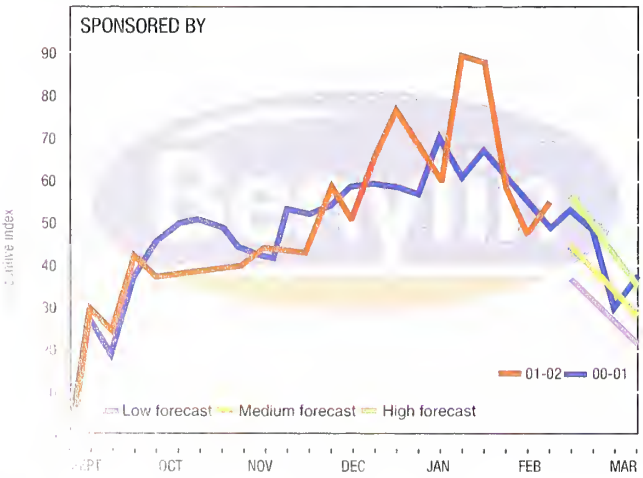
Continue on Alert

KEY FACTS

Benylin

- The UK remains on Alert Status
- Following a recent decline, incidences of cough, cold and flu are again increasing
- Coughing remains the most common symptom

Information updated weekly by SDI



Bioforce harnesses nature

A vitamin C supplement made from fruit has been introduced by Bioforce.

Nature-C is made to a Swiss formula from acerola, passion fruit, sea buckthorn, blackcurrant and lemon. Each tablet contains 100mg of natural vitamin C and the complete C complex of bioflavonoids, hesperidin and rutin. Two tablets a day provide 333 per cent of adult RDA.

According to Bioforce, natural sources of vitamin C are the easiest to absorb – Nature-C's tablets contain just the right amount of vitamin C that the body can absorb at one time.

Nature-C retails at £6.99 for a pack of 60 tablets.

For more information:

Bioforce UK
www.bioforce.co.uk
Tel: 01294 277344.

A&D's BP monitor now has added features

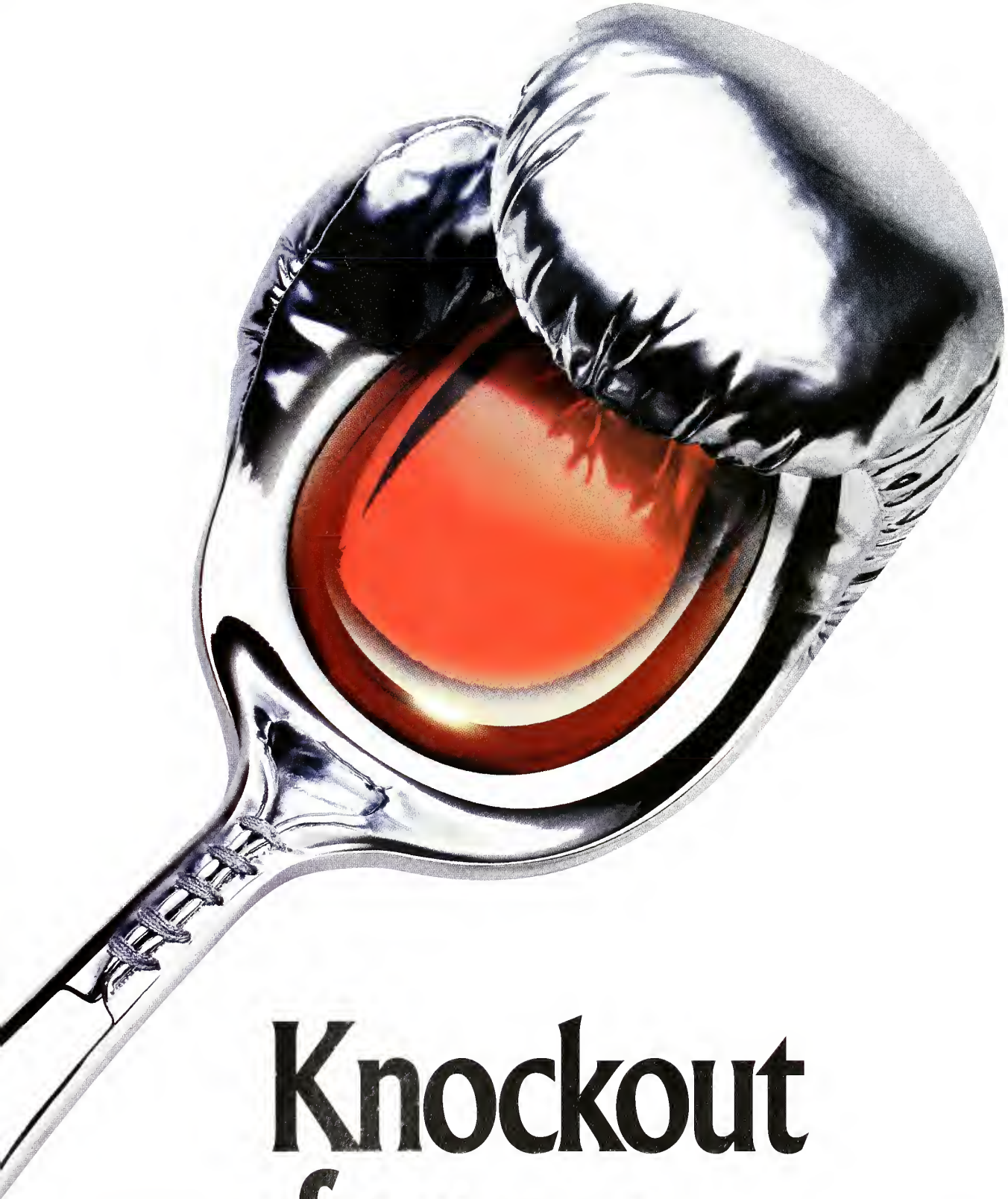
A&D is launching a blood pressure monitor on March 1, which features an irregular heartbeat indicator. A memory function stores the time and date of up to 30 readings.

The UA-787 BP monitor also includes a larger LCD, which shows systolic, diastolic and pulse readings simultaneously. A clock function can be set up for three alarm settings daily to remind the user to take their blood pressure. Comprehensive instructions are included.

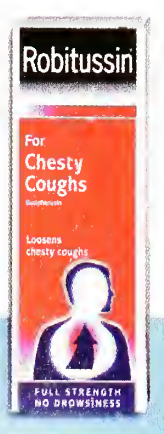
The product, which includes a two-year guarantee, has an "easy-fit" pre-formed cuff that fits larger arm sizes up to 36cm in circumference.

Price: £89.99

Pip code: 284-2615
A&D Instruments
Tel: 01235 550420.



Knockout performance



The UK's fastest growing cough medicine brand*

Robitussin

*Trade Mark

Frontshop

Valupak range offers eight newcomers

BR Pharmaceuticals is adding a range of eight supplements to its Valupak brand.

The products offer one month's supply of 30 tablets, retailing at £1.49, and the range comprises Glucosamine (500mg), Glucosamine and Chondroitin (400/100mg), Royal Jelly (150mg), Propolis (500mg), Chewable Vitamin C (500mg), MSM (1,000mg), Starflower Oil (500mg) and Omega 3 Fish Oil (500mg).

The company says the products reinforce Valupak's proposition of offering "unbeatable value without compromising on quality".

For more information:

Pip codes: Glucosamine: 285-5179; Glucosamine & Chondroitin 285-5187; Royal Jelly 285-5195; Propolis 285-5203; Vitamin C 285-5211; MSM 285-5237; Starflower Oil 285-5245; Omega 3 Fish Oil 285-5302

BR Pharmaceuticals Customer Service

Tel: 0113 275 0000.

A potent move by Seven Seas with glucosamine

Seven Seas has introduced a supplement called Seven Seas High Potency Glucosamine Sulphate with Omega 3.

The product is a high strength formulation which has been developed to help maintain healthy joints and cartilage.

Each capsule contains 500mg of glucosamine sulphate – a naturally-functioning element made by the body, and present in joints, tendons and ligaments. Omega 3 is a naturally-occurring fatty acid that helps maintain supple joints.

Seven Seas says the health sector for joints is one of the fastest growing within pharmacy, and is now as big as established areas, such as calcium and vitamin E.

The relatively new glucosamine sector is worth £14 million.

Price: Seven Seas High Potency Glucosamine Sulphate with Omega 3 (30 capsules), £10.49; Seven Seas High Potency Glucosamine with Chondroitin & Omega 3 (30 capsules), £9.99.

Pip code: glucosamine sulphate: 278-1938; glucosamine with chondroitin: 273-4507

Seven Seas

Tel: 01482 375234.

Website gets Sporty look

Sports supplements specialist SND has redesigned and relaunched its website after research into what its target audience wanted.

The site has a clear layout and is easy to navigate, with a drop-down bar menu to allow visitors to click and choose which sections they want to access.

The brand section features the whole SND range, with details of product benefits and usage and visitors to the site can buy online. Other sections include research and news.

For more information:

www.snd-uk.com

Inbrief

Duck is in a lather over Games

Imperial Leather's dancing duck is getting into a lather over the Commonwealth Games in a TV ad which runs until mid-March and features the Games logo. Imperial Leather is the official Personal Care sponsor for the Games, which are being held in Manchester from July 25 to August 4.

For more information:

Cussons (UK) Ltd

Tel: 0161 491 8000.

Taking Vantage of offers for mum

AAH Pharmaceuticals is offering Vantage pharmacists the chance to capitalise on health and beauty sales in time for Mother's Day on March 10. Customers can save a third on Radox Herbal Bath and moisturisers from the Olay Skincare ranges, with Olay Moisturising Bodywash at half price.

A buy one, get one free offer on Dove shampoo and conditioner packs is being supported by a national TV campaign this month.

Point of sale material and in-store posters are available to support the promotion.

For more information:

AAH Pharmaceuticals Ltd

Tel: 024 7643 2000.

NICOTINELL® TTS 10, 20, 30
NICOTINELL® FRUIT & MINT 2MG & 4mg CHEWING GUM
NICOTINELL® MINT 1MG LOZENGE

Presentations: Transdermal patch containing nicotine, available in three sizes (30, 20 and 10cm²) releasing 21mg, 14mg and 7mg of nicotine respectively over 24 hours. Nicotine chewing gum containing 2mg and 4 mg nicotine, in fruit and mint flavours. Mint flavoured nicotine lozenge containing 1mg nicotine. **Indications:** Treatment of nicotine dependence, as an aid to smoking cessation. **Dosage and Administration:** Stop smoking completely when starting treatment. **Patch:** For those smoking 20 or more cigarettes a day Nicotinell TTS30 (Step 1) once daily. Those smoking less should start with Nicotinell TTS20 (Step 2) once daily. Different strength patches permit a stepwise reduction in nicotine dose over treatment periods of 3-4 weeks with each strength patch. Maximum recommended treatment period three months (but if abstinence not achieved after three month period, further treatment may be recommended following a re-evaluation of the patient's motivation by a clinician) **Gum:** One piece of gum to be chewed when the user feels the urge to smoke. Normally, 8-12 pieces per day, up to a maximum of 25 pieces of 2mg gum per day or 15 pieces of 4 mg gum per day. After 3 months, the user should gradually cut down the number of pieces chewed. **Lozenge:** One lozenge to be sucked when the user feels the urge to smoke. Normally, 8-12 lozenges per day, up to a maximum of 25 lozenges per day. After 3 months, the user should gradually cut down the number of lozenges sucked. **Children and young adults:** To be used in people under 18 years only on medical advice. **Contra-indications:** Non smokers, occasional smokers. As with smoking, Nicotinell is contra-indicated during acute myocardial infarction, unstable or worsening angina pectoris, severe cardiac arrhythmias, recent cerebrovascular accident, skin diseases preventing patch application and known hypersensitivity to nicotine. **Precautions:** Hypertension, stable angina pectoris, cerebrovascular disease, occlusive peripheral arterial disease, heart failure, hyperthyroidism, diabetes mellitus, renal or hepatic impairment, peptic ulcer, fructose intolerance (gum only), pheochromocytoma (gum & lozenge only). Discontinue use if a persistent skin reaction occurs when using the patch. Keep out of the reach of children at all times. **Pregnancy & Lactation:** To be used only on medical advice. **Side Effects:** Events which may be related to smoking cessation include headache, sleep disturbances, gastro-intestinal disturbances, and myalgia. **Nicotine Patches:** most common adverse effects are reactions at the application site (usually erythema or pruritus). **Nicotine Gum & Lozenge:** May cause throat irritation, hiccuping, minor indigestion or heartburn. **Legal Category:** GSL. **Product Licence Nos, Trade Price and Suggested Retail Price:** Nicotinell TTS10 (PL 0030/0107) in packs of 7 patches £9.11, £15.99; Nicotinell TTS20 (PL 0030/0108) two day starter pack £2.56, £4.50, 7 patches £9.40, £16.49; Nicotinell TTS30 (PL 0030/0109) two day starter pack £2.84, £4.99, 7 patches £9.97, £17.49 and 21 patches £24.51, £42.99. Nicotinell Fruit 2mg Chewing Gum (PL 0030/0187) and Nicotinell Mint 2mg Chewing Gum (PL 0030/0189) in packs of 12 £1.59, £2.79, packs of 24 £3.01, £5.29 and packs of 96 £8.26, £14.49. Nicotinell Fruit 4mg Chewing Gum (PL 0030/0188) and Nicotinell Mint 4mg Chewing Gum (PL 0030/0190) in packs of 12 £1.70, £2.99, packs of 24 £3.30, £5.79 and 96 £10.25, £17.99. Nicotinell Mint 1mg Lozenge (PL 0030/0146) in packs of 12 £1.70, £2.99, packs of 36 £4.27, £7.49 and packs of 96 £9.11, £15.99. **PL Holder:** Novartis Consumer Health, Horsham, RH12 5AB. **Date of Preparation:** Jun 2001

Just another way to help? Nicotinell were the first to introduce a lozenge to help smokers quit. Our sugar free lozenges are an ideal way to discreetly beat the craving. We have a range of patches, gum and lozenge so you can find what's right for your customers. We can also help in other ways; call the Nicotinell helpline manned by QUIT councillors on our free phoneline: 0800 917 3333. Or visit www.nicotinell.com. There's a better chance of quitting with Nicotinell.

It needn't be hell with Nicotinell®

Frontshop

Care range takes poster campaign to Pharmasites

Thornton & Ross is backing the Care range with a poster campaign that uses Pharmasites locations around the UK.

The campaign uses the "Why pay more" strapline that highlights Care's value for money. It will feature in over 3,500 pharmacies.

Care's good value theme will be used in other promotional campaigns during the year.

Products featured within the Pharmasites campaign include Ibuprofen Gel, Senna Laxative Tablets and Cystitis Relief.

Around 1,350 of the Pharmasites will be large illuminated posters in the front of the pharmacy shop window. The remaining Pharmasites will be positioned on the dispensary shelf to attract in-store customers.

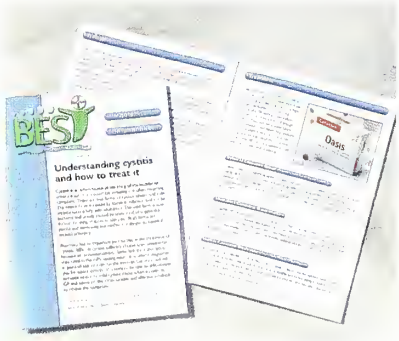
The poster campaign will run for four weeks.

For more information:

Thornton & Ross
Tel: 01484 842217.

Bayer offers BEST written cystitis education

Bayer has launched the latest addition to its BEST (Bayer Education Support & Training) folder for pharmacy assistants with the cystitis module – *Understanding Cystitis and How To Treat It*.



The BEST folder, endorsed by the NPA, offers guidance to pharmacy assistants, information on diagnosis and treatment options, a round-up factfile and a quiz to test knowledge on the topic covered.

The cystitis module is the fifth in a series of six, covering common conditions. Previous modules cover thrush infection, fungal skin infection, insect repellents and haemorrhoids. The next module is scheduled to cover cold sores.

For more information:

Laser Healthcare
Tel: 01202 780558.

Nailcare goes stainless

Nailcare specialist Mavala is launching a range of stainless steel manicure instruments and adding two extra products to its chrome-plated range.

All the products can be displayed in a counter-top showcase designed to offer sales impact and security.

The premium stainless steel range features seven products, including curved nail scissors, cuticle scissors, hard nail tweezers, nail nippers and cuticle nippers. The products can be regularly immersed in sterilising solution without losing their appearance.

The new chrome plated products are: Baby Nail scissors and a Splinter Tweezer.

Mavala has also launched a pen – Mavapen – which releases cuticle oil. Mavapen guides the oil around the contours of the cuticle to smooth and soften the skin. It retails at £6.40.

For more information:

Mavala (UK) Ltd
Tel: 01732 459412.

Scriptlines

HRT data update

The Committee on Safety of Medicines has reviewed the prescribing of hormone replacement therapy, following an earlier review of oral contraceptives.

Now on first prescribing of HRT and at follow-up, a physical examination may not always be necessary and should only be performed if indicated by the patient's medical history, taking into account the contraindications of the HRT drug.

Novo Nordisk has updated the SmPC for Kliofem, Trisequens and Trisequens Forte to include a standard warning to this effect.

For more information:

Novo Nordisk
Tel: 01293 613555.

TV next week

Bassett's Soft & Chewy Vitamins: GMTV, C5, Sat

Blistex: GMTV

Clearblue Pregnancy Test Kit: All areas + C5 except GTV, U, CTV,C4, TSW

Eumovate Eczema and Dermatitis cream: B, G, Y,, HTV, TT

Fybogel: GMTV, Sat

Gaviscon Tablets: All areas

Haliborange: GMTV

Imodium: All areas

Kalms: GMTV, Sat, C5

Lucozade Sport: All areas except U, CTV, C4, GMTV

Neutrataste: G, Y, A, M, LWT, TT, C4

Nicorette: All areas

NiQuitin CQ: All areas except U, CTV, TSW

Nivea Hand Age Defying Crème Q10: All areas

Olbas: C5, GMTV, Sat

Panadol: U

Pearl Drops: All areas + C4, C5, Sat

Senokot: All areas

Seven Seas Cod Liver Oil: G, Y, A, M, LWT, TT, C4

Throaties Pastilles: GMTV

Venos: GMTV

Wella Vivality: All areas

Zovirax: C4, C5, Sat

PharmaSite for next week: Zovirax & Thornton & Ross Care Range – Window, **Midrid** – In-store, **Thornton & Ross Care Range** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Q&A

Another endorsement puzzler – with the answer and rationale behind it explained by the Pharmacy Practice Unit at King's College, London

NAME

Age if under 12 years

yrs. mths. Address

Pharmacy Stamp

Pharmacist's pack & quantity endorsement	No. of days treatment N.B. Ensure dose is stated		NP	
Made up with 85ml purified water	Amoxicillin syrup 125 mg/5ml Sig: 5ml tds Mitte: 100ml			

Q **For reasons of good practice you decide to make up this prescription, and all reconstituted antibiotic mixtures, with purified water. Would you be reimbursed for it?**

ANSWER: Normally, no. The BNF states that when "water" is specified as a reconstitution vehicle, it means either potable water freshly drawn from the public water supply and suitable for drinking (ie tap water) or freshly boiled and cooled purified water. However, payment will only be made by the Prescription Prieing Authority for purified water for reconstituting this preparation if a) the the prescriber specifically orders it, or b) contractors have been informed by the local health authority that tap water is unsuitable for dispensing purposes. For some preparations the manufacturer may advise the use of purified water, or a pharmacist might decide that using tap water would produce an undesirable change in the medicament, in which case payment would be made for purified water. But that would not apply to Amoxicillin syrup or most other antibiotic mixtures. If purified water is used, it should be freshly boiled and cooled.

Jason Bennion

Community pharmacists have some good news to celebrate, reports Dr Darrin Baines

Let's praise LPS

It's time to break out the champagne. For years now, everything that could go wrong has gone wrong. No contractor in the country needs reminding about the recent financial disasters, from extra spending on clinical governance to rising locum costs.

But despite the doom and gloom, independents and retail chains now have a genuine reason to pop their corks.

Soon the stability will return to the business of pharmacy, with guaranteed incomes, stable resale values and perhaps higher revenues for the chosen few.

Later this year, pharmacies that have chosen to do so will be able to submit three year plans to the Department of Health outlining what they would like to do, and how much it will cost.

For contractors tired of waiting for their national representatives to do something positive for their businesses, the frustration may soon be over.

Pharmacies will be soon be able to elect to provide dispensing, and other, innovative, services to local patients under the Government's new Local Pharmaceutical Services (LPS) scheme.

Under this voluntary initiative, lucky contractors will be able to directly negotiate their own contracts, set their own targets and agree financial terms that suit themselves and the NHS.

The LPS scheme was made law by clauses 29 to 41 of the Health and Social Care Bill enacted in 2001.

Since this legislation was passed, the Department of Health has been working on proposals for the scheme and recently asked for comments before guidance is published in spring 2002.

Although the scheme has not been officially launched yet, enough information has appeared in the public domain and the pharmacy press to predict what the regulations governing the LPS scheme may be like.

LPS pilots are likely to provide an alternative to the existing national contract that will:

- develop innovative ways of contracting for core pharmacy services like dispensing
- explore ways of providing a wider range of services within community pharmacy
- offer community pharmacists and pharmacy owners an opportunity to work within a contract they help design
- provide better quality services and care to patients.

For contractors running a business, the scheme offers new opportunities and new constraints.

For example, LPS providers will be free to provide innovative services such as diagnostic testing, or health education.

However, they will have to continue dispensing, stay within budget, supply pilot data and facilitate monitoring by a national evaluator and local PCT.

Although there may be much to celebrate, as yet unrevealed aspects of the scheme could be equally important.

- National and local pharmacy bodies may have no input into day-to-day issues such as budget-setting and appropriate fees, as the scheme operates solely (and privately) between the NHS and LPS provider sites.
- Local Pharmaceutical Committees, Primary Care Trusts and dispensing doctors will not be able to directly run LPS pilots (unless they form bodies corporate) and they have no special rights of information or veto.
- As they may fund dispensing, LPS pilots could be designed to protect traditional community pharmacy, making innovative services a necessary sideline for many LPS providers.

These factors could create an opportunity for contractors to move away from a nationally-negotiated remuneration system to local arrangements.

As an example, a pharmacy with an NHS turnover of £250,000 could (in theory) bid for £270,000 to provide its existing dispensing service plus a few flashy add-ons, and have this money paid in monthly instalments for its whole time in the scheme.

If it negotiated its contract correctly, this pharmacy could become immune to reductions in the dispensing fee, as LPS makes its revenue a local issue.

As it involves locally-negotiated, three year contracts, HAs and PCTs could use the LPS initiative to re-organise local pharmacy outlets, for example, by opening new premises.

Indeed, subject to Government approval, an important feature of LPS may be the ability of HAs and PCTs to jointly create "designated" neighbourhoods, premises and descriptions of premises.

At present, NHS pharmacy is mainly funded from the global sum, which can only be secured locally if there is a dispensing pharmacist, and a doctor nearby who prescribes.

In deprived parts of the UK that lack a pharmacy, a general practitioner, or both, patients often suffer because the local PCT is unable to secure pharmacy monies unless dispensing takes place.

"Once budgets are allocated, risk management will become a critical issue"

Under LPS, however, it will be theoretically possible for PCTs to bid for pharmacy funds without a pharmacy being open.

Therefore, PCTs may use the LPS scheme to promote access (or extend services) in areas previously not viable (or desirable) to contractors paid by the dispensing fee.

To date, much emphasis has been placed on the possible design and organisation of LPS pilots.

However, once the scheme is launched, the most important factor for participating providers will be money.

Indeed, LPS is not primarily about pharmacy services, but about moving from the national global sum to local pharmacy budgets distributed by PCTs.

In relation to money, the first issue facing LPS pilots will be deciding how much to charge for their services.

Although alternative funding methods could be used, a satisfactory short-term approach could be budgets based upon the total amount currently received from dispensing, plus an uplift for IT and pilot development of about 10-15 per cent.

For new providers, on the other hand, the cost of proposed services could be calculated and an appropriate budget allocation submitted to the DoH.

Once budgets are allocated, risk management will become a critical issue to cash-limited pilots.

If they opt for a fixed, annual budget, LPS providers will have to manage the risk of their expenditure rising above their revenues, as their pilots attract unforeseen demand.

The pilots' successes will consequently depend on their ability to secure appropriate budgets, control costs and ration the services they provide.

However, providers will not be exempt from their duties and ethics as pharmacists, and rejecting dispensable scripts will not be an acceptable way of managing their financial affairs.

Indeed, it is likely that most HAs and PCTs will introduce strict contracts and pilot monitoring that discourage reductions in dispensing volumes as a way of handling their costs.

Whether particular pilots are successful or not will depend, to a large degree, upon the contracts they sign.

Counter-intuitively, however, over-long or complex contracts may not contribute to pilot success, as longer or more detailed agreements don't mean that a pilot will work well in practice.

Indeed, evidence from contracting in other parts of the NHS suggests that good relationships between purchasers and providers are more important than the finer details of contracts.

Therefore, pilots should attempt to agree contracts that are explicit about the services they plan to offer and the standards they will meet, but they should only view this as a starting block from which to launch into LPS success.

For providers who find their agreements unacceptable in the longer-term, the LPS scheme offers some opportunities for contract renegotiations, as well as the right for providers to return to the standard regulations for community pharmacies.

In a world in which the national dispensing fee has been cut, some pharmacists may decide to take greater control over their own destinies by joining the LPS scheme.

However, potential providers must realise that their LPS proposals must first be accepted by their local HA and, then, the DoH.

In the first instance, interesting or safe bids may receive approval.

However, before final contracts are negotiated, wise providers will strive to learn more about alternative approaches to contract design, budget-setting and controlling pilot costs.

Providers who concentrate solely on deciding what services to provide and not on management issues may find that their plans never achieve success.

If the DoH and Parliament allow the LPS scheme to be designed in the way described here, an understanding of management (rather than an in-depth knowledge of medicines) may be what marks out successful pharmacies within the NHS.

Key features

1. The LPS scheme is voluntary, no pharmacy has the right to join, and the existing arrangements for non-participating pharmacies still remain in place.

2. Interested parties must register their outline proposals with their local HAs/PCTs, which must select proposals for submission to the DoH.

3. Outline proposals may be submitted by anybody, including existing pharmacy contractors, other individuals, bodies corporate, NHS Trusts, or may be devised by HAs/PCTs themselves.

4. Health authorities will initially lead in putting forward and managing pilots, and this role will eventually pass to PCTs.

5. PCTs will not themselves be providers of LPS, and no formal role has yet been given to Local Pharmaceutical Committees.

6. Pilots must include dispensing services (whether to general or particular groups of patients) and may not include dispensing by doctors, unless they form new organisations for providing LPS services.

7. Pilots can include arrangements for the provision of training and education, including for those involved (or who may later be involved) in the scheme.

8. Pilots may not be combined with PMS or PDS in the same contract although a separate LPS contract may be held alongside either.

9. Although some models will be more appropriate than others, there is no favoured type of provider arrangement for pilots.

10. Subject to government regulations, HAs/PCTs will have the power to designate neighbourhoods, premises and description of premises for the purposes of LPS.

Dr Darrin Baines is the director of medM Ltd. Details of the company's conferences, workshops and advice services on the LPS scheme are available at *www.medm.co.uk*

Hidden hazards

Some hazards in the workplace are obvious and easy to control. Others, however, are less easy to spot or may not occur to you until something goes wrong. Andrea Turner, Lloydspharmacy's business unit manager for training and development, and Phil Robinson, Gehe UK's safety and environmental manager, report

Many pharmacies employ young people. In safety law, a "young person" is defined as someone under 18 years of age, possibly Saturday staff or students working in the pharmacy as part of a work experience scheme.

UK accident statistics clearly show that because of their immaturity and lack of experience, younger people are more likely to be at risk.

As an employer, you are required to complete a risk assessment of the activities the young person will be undertaking, together with any other assessments you have already completed. This specific assessment must take into account the level of the young person's lack of experience. You will need to record this assessment and may be asked to provide this in the event of a work experience scheme to the school.

1. New and expectant mothers

As an employer you should review the tasks your employee undertakes and assess any risk to the employee, her unborn child or to a child she is breast feeding.

Risks vary at different stages of the pregnancy. The tasks should be reviewed monthly and should include discussions with and feedback from the new or expectant mother.

Typical risks are:

- standing for long periods
- lifting boxes
- workstation design.

Many of the issues are easily dealt with by a change in work routine or arranging for others to handle stock. As with all assessments, these must be recorded and available for inspection by the local environmental health officers.

"Many companies make the mistake of assuming that by creating an MSDS file they have fulfilled their duties under COSHH"

2. COSHH

Control of Substances Hazardous to Health. These regulations are designed to protect staff from hazardous substances in use in the workplace and as with all regulations, they require the employer to conduct a risk assessment.

A hazardous substance is clarified as:

- toxic
- harmful
- corrosive
- irritant.

Traditionally COSHH would have had a significant impact on a dispensary carrying out extemporaneous dispensing.

As most pharmacies use packaged products, the risk of exposure is greatly reduced and would only become an issue in the event of a spillage.

However, various substances such as cleaning materials are used, and these will need to be assessed.

Information is available on the packages containing products. Details are also available on material safety data sheets (MSDS), which most manufacturers are obliged to produce for each product.

Many companies make the mistake of assuming that by creating an MSDS file they have fulfilled their duties under COSHH; unfortunately this is not sufficient.

While the MSDS will provide details on the product, it does not specify the hazards associated with using it. As mentioned previously, many products dispensed, which are perfectly safe if used correctly, CAN be hazardous if used incorrectly, ie, if they are taken by a child or the dose is exceeded.

In another instance, you may be using a cleaning product in the pharmacy which the MSDS states should be used in a well-ventilated area. Staff may be using this in a small cupboard and could be affected by the fumes.

Possible actions to be considered with COSHH are:

- discontinue – do you have to use or keep this product?
- substitute – could you use a safer product?
- what risks are there to staff – can it affect their skin, is it harmful to breathe in?
- what type of protection does your staff need – gloves, goggles etc?

Remember legislation also covers the use of safety equipment – you must ensure the correct equipment is used for the specific substance.

This is the second article in the series, which is based on a new health & safety training programme introduced by Lloydspharmacy

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1. Is he aware of expected gross profit margin within retail chemist business?	❑	❑
2. Is he aware of how goodwill of retail chemist is valued generally?	❑	❑
3. Is he aware of the payment methods of the PPA?	❑	❑
4. Is he aware of the average stock holdings of retail chemists of similar size to yours?	❑	❑
5. Is he interested in your business? And the future of your business?	❑	❑
6. Is he imaginative and proactive?	❑	❑
7. Does he guide you on how to increase your profits?	❑	❑
8. Does he insist on and help you prepare quarterly management accounts so that you know what profit you are making? What tax you will have to pay and discuss your profit margins with you so that you can work towards improving these and therefore your net profit?	❑	❑
9. Does he have contacts in the pharmaceutical industry with stock takers, EPOS providers, shop fitters, purchase/sale agents, and specialist finance providers?	❑	❑
10. Is your top rate of tax 20%? If not, why not? Are you therefore paying 40%?	❑	❑
11. Has he reduced your tax liability by 50% annually by restructuring your business. Average tax savings would be about £8,000 p.a.	❑	❑
12. Has he suggested the possibility of setting up a personal or company pension scheme (SIPPS or SSASs)? This would enable you to get tax relief and allow you to purchase commercial properties in your pension fund, without having to pay capital gains tax	❑	❑
13. Can he set up employee benefit trusts, allowing you to obtain a full tax deduction for payments made e.g. payments of £50,000 can reduce your tax liablility by about £10,000	❑	❑
14. Can he set up an ERP? There are significant tax advantages of this scheme if set up correctly.	❑	❑
15. Has he set up offshore companies and trusts that allow you to accumulate vast amounts of wealth totally tax-free?	❑	❑
16. Does he help you plan to keep your wealth? Have you done your Inheritance tax planning?	❑	❑
17. Does he plan for the future sale of your business? The worst scenario should be a 10% tax liability, the best is no tax liability.	❑	❑
18. Do you receive advice throughout the year on how to reduce your tax bills?	❑	❑
19. Does he help you to source commerical properties?	❑	❑
20. Does he prepare your accounts and tax returns on a timely basis?	❑	❑

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Feeling stressed?	☐	☐
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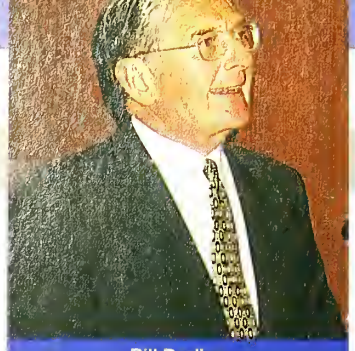
Bill Darling


George Fairweather

Bill Darling, past president of the Royal Pharmaceutical Society, has been appointed president of The Pharmaceutical Group of the European Union for this year. **George Fairweather** will be joining Alliance UniChem as group finance director from the beginning of April. He succeeds **Geoff Cooper** who was appointed deputy chief executive in September last year.

Alpharma has appointed two new board directors: **Russell Howard,** vice-president business development and strategic marketing, and **Andrew Collier,** director of sales and marketing. Antisoma, the biopharmaceutical company, has appointed **Dr Lloyd Kelland** as head of laboratory.

This week

1977

Adrienne was heading for the top

Adrienne de Mont, now (jolly good) Fellow of the Royal Pharmaceutical Society, was *C&D*'s very own Purdy in 1977. However, her picture had been included not to demonstrate her similarity to the *New Avenger*'s first lady but to celebrate her appointment as assistant editor. Sorry, Adrienne!

Lambeth walk for Queenie

Also in February, a sprightly 77-year old Queen Mother officially opened the new Lambeth headquarters of the Pharmaceutical Society (as it was then). *C&D*'s invitation to celebrate the silver anniversary of this important occasion must have got lost in the post, or have the powers-that-be simply forgotten?


Deirdre McAree, left, is pictured with her PhD supervisor, Dr Eileen Scott, of Queen's University, at the graduation ceremony

Teacher practitioner for Boots gains PhD

Deirdre McAree, teacher practitioner for Boots at Queen's University, Belfast, has been awarded a doctorate for her research *Women's Health – Community Pharmacy Care.*

Dr McAree, who works at the Boots store in Donegal Place, Belfast, said: "I am delighted to be awarded this degree which represents over four years' research. It would not have been possible without the support and commitment from colleagues at both Boots and the university."

Subscription winners

Five people have won a free year's subscription to iCE – *C&D*'s new online continuing professional development course.

The winners were chosen at random from those who had suggested topics for future seminars. The most popular suggestions were common skin conditions, depression and drug interactions. Seminars will be produced on these three topics.

The winners are: Tracy Clarkson, Rod Tucker, Clare Tooley, John Larvin and Carolyn Ward.

A year's subscription costs £48, but anyone passing the free demonstration seminar will be e-mailed a certificate for an hour's continuing education. iCE is hosted on Dotpharmacy *(www.dotpharmacy.com)* – click on the iCE logo.

Five get ready for Indonesian adventure

Five pharmacists left for Surabaya, Indonesia this week to help provide intensive training courses in medicines information and clinical pharmacy.

Dr Chik Kaw Tan, senior pharmacist at North Staffordshire Hopsital is leading the team which includes:

Rachel Kenward (Lincoln Hospital/Nottingham University), Dr David Scott (Radliffe Hospital, Oxford), Alison Eggleton (Addenbrooke's Hospital, Cambridge) and Sadia Khan, an information pharmacist at the Royal Pharmaceutical Society.

The team will be speaking at a national seminar promoting medicines information and clinical pharmacy and hope to cultivate links with the Indonesian community and hospital pharmacists.

The trip has been funded by the British Council. Dr Mohamed Aslam, director of clinical pharmacy at Nottingham University and visiting professor at the University of Surabaya has been "instrumental" in setting up the trip.

Ms Khan said: "The training courses are an excellent opportunity to continue helping a country where medicines information resources are scarce, clinical pharmacy is developing and pharmacy practice is still focused on dispensing."

Earthquake appeal latest

An appeal *C&D* helped launch a year ago *(C&D, February 10 2001, p34)* has helped to raise over £3,500 for the Gujarat Earthquake Relief Fund.

Sunderland pharmacists Umesh Patel, Damini Patel, Sailesh Patel, Ash Agarwaal and David Carter set up the fund following the tragic earthquake last January.

The money will help to buy an ambulance that will enable a medical team to visit victims in remote areas.

Umesh Patel, appeal co-ordinator, has asked us to pass on the committee's thanks to those who made donations to the fund.

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DIOMED DEVELOPMENTS